

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Balto.

15-4

(49)

01383

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Long Beach (No. Middle River St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Karl Hacker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Sept. 1, 1860  
(Month) (Day) (Year)

7 AGE

67 yrs. 5 mos. 21 ds. or min. ?

If LESS than 1 day.....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)Tailor

9 BIRTHPLACE (State or country)

Leppo det. Mch. Hohenhaus Germany  
Hacker

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

GermanyNot knownGermany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frieda Wister(Address) 402 N. Rose St.

15

Filed Feb. 22, 1920 John G. Connolly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 22, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb 10, 1920, to Feb 22, 1920that I last saw him alive on Feb 22, 1920and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH was as follows:

Carcinoma of Prostate  
(Duration) 2 yrs. 5 mos. 21 ds.

Contributory Secondary

(Duration) 2 yrs. 5 mos. 21 ds.(Signed) James D. White M.D.Feb 22, 1920 (Address) Essex, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 22 yrs. 5 mos. 21 ds. In the State, 22 yrs. 5 mos. 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Md Feb. 25, 1920

20 UNDERTAKER

Mrs. G. Miller & Son 2334 Jefferson St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iuauition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU V. S.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Upperes (No. \_\_\_\_\_)

2 FULL NAME James W. Hagen

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 84

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH October 6 1868  
(Month) (Day) (Year)

7 AGE 64 yrs. 11 mos. 20 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER John W. Hagen

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Euton

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. James W. Hagen

(Address) Upperes Md

15 Filed Sept 28 1930 C. E. Fowke M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 26th 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 2nd 1930 to Sept 26 1930, that I last saw him alive on Sept 26 1930, and that death occurred on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH \* was as follows:

Cardiovascular renal disease

(Duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Myocardial compensation  
Secondary

(Signed) James G. Laffey M. D.  
9-26 1930 (Address) Registers Town, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hawford Co  
McKendree Church DATE OF BURIAL 9/29 1930

20 UNDERTAKER Edw C Tipton ADDRESS Hampstead Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scapula, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1900

BUREAU

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## 1 PLACE OF DEATH

County Balto

13555

101-a

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. Spring Grove Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME William P. Bagerty

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Feb 25 1884  
(Month) (Day) (Year)7 AGE 46 yrs. — mos. — ds. or — min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Mid.10 NAME OF FATHER Patrick Bagerty11 BIRTHPLACE OF FATHER (State or country) Ireland12 MAIDEN NAME OF MOTHER Mary Kileen13 BIRTHPLACE OF MOTHER (State or Country) Mid.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theresa Kelly (Sister)(Address) 1041 Bayford Ave15 Filed 11-29 1930 H. H. H. H. H. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 27, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Feb 25 1930 to Nov 27, 1930  
that I last saw him alive on Nov 26, 1930and that death occurred on the date stated above, at — m.  
The CAUSE OF DEATH \* was as follows:Lobar Pneumonia  
(Duration) — yrs. 4 mos. — ds.Contributory Toxic Condition  
Secondary (Duration) — yrs. 2 mos. — ds.(Signed) Blair E. Garrett M. D.  
Nov 27 1930 (Address) Catonsville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 9 yrs. 1 mos. — ds. In the State — yrs. — mos. — ds.Where was disease contracted if not at place of death? at place of deathFormer or usual residence Balto Md.19 PLACE OF BURIAL OR REMOVAL Cathedral DATE OF BURIAL Dec 1, 193020 UNDERTAKER Rita Wiedefeld ADDRESS 914 Greenfield

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1920

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## 1 PLACE OF DEATH

County

Paldmont

14680

(31)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

42

Village or City

Lansdowne

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Elizabeth Rauch Halbig

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

July 4, 1883

(Month)

(Day)

(Year)

7 AGE

47 yrs. 5 mos. 18 ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore City Md.

10 NAME OF FATHER

Harry Rauch

11 BIRTHPLACE OF FATHER

(State or country)

Saxe-Weimar Germany

12 MAIDEN NAME OF MOTHER

Louisa Bond

13 BIRTHPLACE OF MOTHER

(State or Country)

Saxe-Weimar Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Halbig

(Address)

Lansdowne Md

15 Filed

Dec 23 1930

Registered

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

22 December, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

17 Aug 1929 to 21 Dec 1930

that I last saw him alive on 21 Dec 1930

and that death occurred on the date stated above, at 1205 A

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration)

?

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Blond Woodruff M.D.

22 Dec 1930

(Address) Littleton Heights

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. Maryland

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the

State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

Dec 24, 1930

20 UNDERTAKER

ADDRESS

Geo. Knell

917 Washington

Blond



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc.; Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1911  
BUREAU

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH,  
County Baltimore

05272

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 34Village or City Beckleyville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Zachariah Hale

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed6 DATE OF BIRTH Unknown, 1 \_\_\_\_\_ (Month) (Day) (Year)7 AGE About 87 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Ret Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER William Hale11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Hannah Alban13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Geo Lippy  
(Address) Millers Rd15 Filed May 20 1930 C. E. Froth M. D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 7th 1930 to May 19th 1930, that I last saw him alive on May 12th 1930,and that death occurred on the date stated above, at 9:45 A. M.  
The CAUSE OF DEATH \* was as follows:Cerebral Hemorrhage(Duration) \_\_\_\_\_ yrs. 1 mos. 14 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) S M Resh M. D.  
May 19 1930 (Address) Hampstead Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For hospitals, institutions, transient residents or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Grave Run Md DATE OF BURIAL May 21, 193020 UNDERTAKER Edw. C. Tipton ADDRESS Hampstead Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

1 PLACE OF DEATH

County Baltimore

08967

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 9 38Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Catherine Hae

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH August 25, 1910  
(Month) (Day) (Year)7 AGE 19 yrs. 11 mos. 21 ds. or \_\_\_\_\_ min.? If LESS than 1 day \_\_\_\_\_ hrs.8 OCCUPATION (a) Trade, profession or particular kind of work Office Clerk  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Fairmont. Md.10 NAME OF FATHER Wm. Richard Hae11 BIRTHPLACE OF FATHER (State or country) Maryland.12 MAIDEN NAME OF MOTHER Ruth. C. Cox.13 BIRTHPLACE OF MOTHER (State or Country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Hospital Records--Personal History,

(Informant)

Eudowood Sanatorium, Towson, Md.

(Address)

15 Filed 8/16 1920 A. M. Bacon Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August, 1930  
(Month) 16 (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from March 18, 1920 to Aug 16, 1930.that I last saw her alive on Aug 16, 1930.and that death occurred on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic. Tuberculosis(Duration) 4 1/2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary(Duration) 2 1/2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) W. A. Bridget M. D.1930 (Address) Towson, Maryland.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the life State life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence Maryland.

19 PLACE OF BURIAL OR REMOVAL

Oak Lawn

DATE OF BURIAL

Aug 19, 1930

20 UNDERTAKER

John F. Penny

ADDRESS,

715 Light St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 8 1900

RUB



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

06468

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day... hrs.  
or... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

I HEREBY CERTIFY, That I attended the deceased for

that I last saw him alive  
and that death occurred on the date stated above, at  
The CAUSE OF DEATH \* was as follows:Contributory  
Secondary

(Signed)

6/5

1930

(Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds.

In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

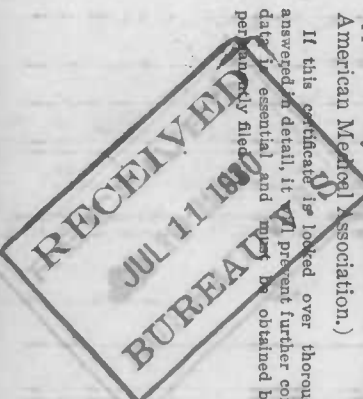
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. REGISTRARS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

03466

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City

Helling Station

St.:

Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John E. Hall

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

March 11, 1884  
(Month) (Day) (Year)

7 AGE

46 yrs. 1 mos. 2 ds. or min.?

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Lewis Hall

11 BIRTHPLACE

OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Samuel Hall

(Address)

Mt. Washington

15

Filed

April 16, 1930

W. P. Butler

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Probably in March, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Body was found in Lake Roland on April 15, 1930. Drowning.

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) W. P. Butler (Coroner) M. D.

192 (Address) Towson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Liberty, Harford Co.

April 18, 1930

20 UNDERTAKER

ADDRESS

Mrs. Kate P. Williams

322 N. Schroeder St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, vertigo, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 7 1900

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PL. YSI-  
CIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact  
statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Rustons No. MD

2 FULL NAME William Hall

07695 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in  
a hospital or institu-  
tion, give its NAME; if  
stead of street and  
number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Jan 7, 1871  
(Month) (Day) (Year)

7 AGE 59 yrs. 7 mos. 3 ds. or 59 min. If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work Book  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Howard Co MD

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER Ann Hall

13 BIRTHPLACE OF MOTHER (State or Country) Frederick Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1

(Address) \_\_\_\_\_

15 Filed July 11, 1920 1800 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 10, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 8<sup>th</sup> 1920 to July 10, 1920

that I last saw him alive on July 6<sup>th</sup>, 1920

and that death occurred on the date stated above, at 4<sup>00</sup> m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory Secondary (Duration) 4 yrs. 4 mos. 4 ds.  
Arterio Sclerosis

(Signed) W. M. D. (Duration) 1 yrs. 1 mos. 1 ds.  
July 11, 1920 (Address) Rustons

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West Liberty Cemetery July 12, 1920

20 UNDERTAKER ADDRESS

J. F. Egan Rustons



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *Falls & Pimlico Rds.* ST.REGISTERED NO. *32*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME *Fortus Hall*(a) RESIDENCE NO. *3110 Haverford Ave. Philad Pk.* ST.

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*wh.*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Apr 26, 30*

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)*Balto Md.*

10 NAME OF FATHER

*Joseph Hall*11 BIRTHPLACE OF FATHER (city or town)  
(State or country)*Rocheater N. Y.*

12 MAIDEN NAME OF MOTHER

*Rose Faltarinos*13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)*N. Y. City*

14

Informant

*Mother*

(Address)

15

Filed

19

*HILMERSON JONES, M.*

Registrar

*May 24, 1931**Dr. E. E. Hildrop*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Apr 26, 30*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 26, 30* 19*30*, to *Apr 26, 30* 19*30*,  
that I last saw h*er* *live* on *Apr. 26* 19*30*.and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Premature Fortus (3 1/2*  
*mos. gestation)*

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *F. L. Badagiacca*, M. D.

19 (Address)

*1117 St Paul St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL*Disposed by parents*

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state FULL USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asplenia," "Anæmia," (merely symptomatic), "Atraphy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

U. S. BUREAU OF VITAL STATISTICS  
JUN 2 1930  
RECEIVED

Received  
JUN 2 1930  
Bureau of V.S.

COPY SENT TO LOCAL REGISTRAR

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup>PLACE OF DEATH  
County Baltimore Co.

Village or City Beltsville Md. (No. \_\_\_\_\_)

<sup>2</sup>FULL NAME Maria Walkman

03467

(50)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 142

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 2, 1861  
(Month) (Day) (Year)

7 AGE 68 yrs. 7 mos. — ds. If LESS than 1 day. hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Ehrt.

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Jacobs

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Maria Walkman  
(Address) Walden Ave

15 Filed April 30 1930 Ge. McKieffer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 31, 1930  
March (Month) 31 (Day) (Year) 30

17 I HEREBY CERTIFY, That I attended the deceased from Jan 29, 1930 to Mar 31, 1930, that I last saw him alive on Mar 30, 1930

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH \* was as follows:

Hypostatic pneumonia  
lungs cardiac insufficiency  
Impossible to state the character of the neoplasm,  
as to whether benign or malignant (Duration) 1 ds.

Contributory  
Secondary

Renal neoplasm  
Hematuria - Cystoscopic  
(Duration) 1 yrs. — mos. — ds.

(Signed) James W. Nelson M. D.  
192. (Address) 10 Sulphur Sp. Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Rouds Park DATE OF BURIAL April 7, 1930

20 UNDERTAKER Margaret S. Flynn ADDRESS 1422 Highland St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

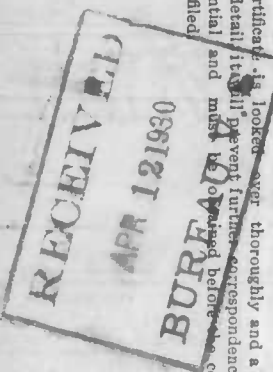
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be completed before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

14681

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 28

Village or City Lutherville

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME T. Edward Hambleton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 26, 1886  
(Month) (Day) (Year)

7 AGE 43 yrs. 5 mos. 27 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Banker  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Frank S. Hambleton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna B. Crawford

13 BIRTHPLACE OF MOTHER (State or Country) Philadelphia, Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Livingston

(Address) Lutherville

15 Filed Dec 23 1930 Wm. P. Butler Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH was as follows:

Suicide (Pistol shot in right temple)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Wm. P. Butler (Coroner)  
Dec 23 1930 (Address) Towson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Greenmount Cem DATE OF BURIAL Dec 24, 1930

20 UNDERTAKER Henry Jenkins & Co ADDRESS Cecil St. E. Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

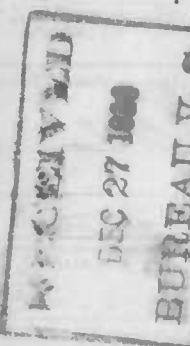
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retcher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

13556

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Dundalk, Md. (No. 6721 Pine AveSt. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Robert William Hammel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH  
March 2nd, 1925  
(Month) (Day) (Year)7 AGE  
5 yrs. 8 mos. 19 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Dundalk, Md.10 NAME OF FATHER Joseph M. Hammel11 BIRTHPLACE OF FATHER (State or country) Baltimore12 MAIDEN NAME OF MOTHER Helen M. Storch.13 BIRTHPLACE OF MOTHER (State or Country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph M. Hammel(Address) Dundalk, Md.15 Filed 11/24/30 W. M. Hammel Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 24th, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920,that I last saw him alive on 1920, and that death occurred on the date stated above, at \_\_\_\_\_ m.The CAUSE OF DEATH \* was as follows:  
Congenital Malformation of the BrainDr. A. W. Reier.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary(Signed) Fredrick H. Litanis M. D.  
11/24/30 (Address) Dundalk, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer DATE OF BURIAL 11/26/30, 1920 UNDERTAKER George J. Smith ADDRESS Balto

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU V. 6

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore Co

06470

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(129)

Registration Dist. No. 34

Village or City Texas (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Anna Eliza Haulplike

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, yes WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH April 15, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 1 mos. 24 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Baltimore Co. Md.

10 NAME OF FATHER Elijah Gordon

11 BIRTHPLACE OF FATHER (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER believe to be Elizabeth Leinwell

13 BIRTHPLACE OF MOTHER (State or country) Balto Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Haulplike  
(Address) Tinnerum, Md.

15 Filed June 8 1930 B. B. Bennett Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 15 1929 to June 7 1930, that I last saw her alive on June 6 1930,

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:  
Chronic Infectious Nephritis  
a Dropsy  
Dilatation of Heart  
(Duration) 7 yrs. 7 mos. 7 ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) B. F. Arnsperg M. D.  
June 7 1930 (Address) Texas Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Joseph Cemetery DATE OF BURIAL June 9 1930

20 UNDERTAKER Wm C. Brooks ADDRESS Sparks Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY taken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 7 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07696

(102)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonville (No. Spring Grove Hospital Sta. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Chas Edward Hanson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 5, 1848  
(Month) (Day) (Year)

7 AGE 82 yrs. 0 mos. 12 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Chas. G. Hanson

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Anna Worthington

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. C. Norris

(Address) Catonville

15 Filed 7/17 1930 John O. Mitchell Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1, 1899 to July 17, 1930

that I last saw him alive on July 16, 1930

and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH \* was as follows:

Pleurisy  
(Duration) yrs. mos. 7 ds.

Contributory Streptococcus infection  
Secondary (Duration) yrs. mos. 7 ds.

(Signed) Doc E. Garrett M. D.  
192 (Address) Catonville, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 47 yrs. mos. ds. In the 82 yrs. 0 mos. 12 ds. State

Where was disease contracted if not at place of death? at place of death

Former or usual residence Hawes County

19 PLACE OF BURIAL OR REMOVAL Belmont Private Cem

20 UNDERTAKER John O. Mitchell & Son

DATE OF BURIAL July 19, 1930

ADDRESS Belmont

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; . . . . ., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 12 1900  
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Balto

Village or City Arbutus (No. 1) Brighton St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 42

2 FULL NAME Hansen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ✓

6 DATE OF BIRTH June 25, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work ✓  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Balto Co Md

10 NAME OF FATHER Peter Hansen

11 BIRTHPLACE OF FATHER (State or country) Austria

12 MAIDEN NAME OF MOTHER Frieda Matal

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Hansen

(Address) Arbutus Ave

15 Filed June 25 1930 H. S. Smucker  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 1930 to \_\_\_\_\_, 1930,

that I last saw him alive on \_\_\_\_\_, 1930,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still born miscarriage

(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) H. S. Smucker M. D.  
June 25 1930 (Address) 2154 Madison

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

14682

## CERTIFICATE OF DEATH. (90)

## 1-PLACE OF DEATH

County

CITY OF BALTIMORE: (No. .... ST. .... WARD)

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

Chesterfield F. Hardage

(a) RESIDENCE NO.

Raspburg Ind.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

about 52

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

W. L. Thomas Co.

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Ga.

10 NAME OF FATHER

unk.

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

unk.

12 MAIDEN NAME OF MOTHER

unk.

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

unk.

14

Informant  
(Address)W. L. Thomas  
Redwood St. Balto.

15

Filed

Dec. 16 1930 John G. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

, 19 ....., to ....., 19 .....

that I last saw him alive on Dec. 14, 1930

and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH\* was as follows:

Acute Cardiac Failure

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted  
If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis?

(Signed) Ed. J. Herrmann M.D.

, 19 (Address) Stenness Run Ind

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Marquette, Ga.

DATE OF BURIAL

Dec. 16, 1930

20 UNDERTAKER

John G. Connolly

ADDRESS

Essex

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (b) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin;

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—suicide. Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Quinns Mills (No. \_\_\_\_\_)

2 FULL NAME Mary Priscilla Hardesty

12193

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 22

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 29, 1913  
(Month) (Day) (Year)

7 AGE 17 yrs. 2 mos. 22 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate  
(b) General nature of industry, business, or establishment in which employed or (employer) Rosewood State Training School; Quinns Mills, Md.

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Joseph H. Hardesty

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Blanche B. Rhodes

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Institutional Records  
Rosewood State Training School, Quinns Mills, Md.  
(Address)

15 Filed Oct 22 1930 W. M. Slader  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 25 1930 to Oct 21 1930, that I last saw her alive on Oct 21, 1930,

and that death occurred on the date stated above, at 11:38 a.m.  
The CAUSE OF DEATH \* was as follows:

Chronic Ulcerative Endocarditis  
(Mitral Regurgitation)

(Duration) Unknown ds.  
Contributory Septic Meningitis  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.  
(Signed) George C. Medsary M. D.  
Oct 21 1930 (Address) Quinns Mills, Md.

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 7 yrs. 8 mos. 16 ds. In the 17 yrs. 2 mos. 22 ds.  
State

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Maryland

19 PLACE OF BURIAL OR REMOVAL Rosewood Cemetery DATE OF BURIAL Oct 22 1930

20 UNDERTAKER J. F. Eberle ADDRESS Baltimore, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

NOV 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

05273

## CERTIFICATE OF DEATH. (198)

52

## 1. PLACE OF DEATH

Baltimore Co. *Granite Ind* ST. \_\_\_\_\_ WARD)

## 2. FULL NAME

*Margaret Harding* ST. \_\_\_\_\_ WARD \_\_\_\_\_(a) RESIDENCE NO. \_\_\_\_\_ (Usual place of abode) ST. \_\_\_\_\_ WARD \_\_\_\_\_  
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced, (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Tom L. Harding*6 DATE OF BIRTH (month, day, and year) *March 12 1875*7 AGE *33* Years *55* Months *12* Days *5* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Colquhoun Virginia*  
(State or country)10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) *Virginia*  
(State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *Virginia*  
(State or country)14 Informant *Tom L. Harding*  
(Address) *Granite Ind*15 Filled *May 9, 1930* *E. E. Nichols*  
Registrar

REGISTERED NO. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 7<sup>th</sup> 1930*

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Punctured Aorta, resulting from knife wound - Homicide*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Arthur J. Corcoran* M. D.  
, 19\_\_\_\_ (Address) *Pikesville Ind*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Grifford Cemetery* DATE OF BURIAL *May 9 1930*20 UNDERTAKER *F. H. Newell* ADDRESS *Pikesville Ind*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital" "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

JUN 2 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Balto.

05274

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

30

Village or City

Woodlawn

(No.)

Franklyn Road

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Charles E. Hochhaus

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widower

6 DATE OF BIRTH

Oct 8

(Month)

1850

(Day)

(Year)

7 AGE

79

yrs.

7

mos.

3

ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired Silver Smith

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Balto. Md.

10 NAME OF FATHER

Anton Hochhaus

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Weigert

13 BIRTHPLACE OF MOTHER

(State or Country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Baker

(Address)

Franklyn Road Woodlawn

15 Filed

5-18

1930

J. J. Herr

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 11, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 11, 1930

to

May 11, 1930

that I last saw him alive on May 11, 1930

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH \* was as follows:

Angina Pectoris

Contributory Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Eugene L. Pearson

M. D.

May 12 1930

(Address)

514 Cherry Lane

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

May 14, 1930

20 UNDERTAKER

ADDRESS

J. J. Herr

156 N. Lingen

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., (*Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Catonsville (No. 16)

Fursting Ave

St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Miss Helen S. Hardee

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, ☒ Single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH November 9<sup>th</sup> 1861  
(Month) (Day) (Year)

7 AGE 68 yrs. 4 mos. 8 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Savannah, Ga.

10 NAME OF FATHER John L. Hardee

11 BIRTHPLACE OF FATHER (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary Helen Stoddard

13 BIRTHPLACE OF MOTHER (State or Country) London, England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Gertrude H. Johnson  
(Address) 127 W. 79<sup>th</sup> St. N.Y.C.

15 Filed 3/17 1930 H. S. Hardee Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17<sup>th</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2<sup>nd</sup> 22<sup>nd</sup> 1930 to 3<sup>rd</sup> 17<sup>th</sup> 1930, that I last saw her alive on March 17<sup>th</sup> 1930, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Carcinoma at lower end of spine

Contributory Secondary Myocarditis & Paralysis of legs  
(Duration) \_\_\_\_ yrs. 2 mos. \_\_\_\_ ds.

(Signed) D. A. Waldron M. D.  
3<sup>rd</sup> 17<sup>th</sup> 1930 (Address) 210 East Presb.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Washington H.C. DATE OF BURIAL Mar. 17, 1930

20 UNDERTAKER Martin W. Hyong ADDRESS 1500 N. 4<sup>th</sup> St. N.W.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 8 1910

BUREAU



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

06471

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonville (No. 18) Spring Grove Hospital Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Laura J. Kare

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)6 DATE OF BIRTH July 7, 1857  
(Month) (Day) (Year)7 AGE 72 yrs. 11 mos. 11 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Michael Kare11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Mary M. Miller13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Morris C. Turner  
(Address) 2613 Md. Ave15 Filed 6/9 1930 County Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 19, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 10, 1909 to June 19, 1930  
that I last saw her alive on June 18, 1930and that death occurred on the date stated above, at 12:50 p.m.  
The CAUSE OF DEATH \* was as follows:Intestinal Obstruction  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.Contributory Toxic Condition  
Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.(Signed) Robert E. Garrett M. D.  
192 \_\_\_\_ (Address) Catonville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 20 yrs. 11 mos. 8 ds. In the State 7 yrs. 11 mos. 11 ds.Where was disease contracted, if not at place of death? at place of deathFormer or usual residence Baltimore, Md19 PLACE OF BURIAL OR REMOVAL London Park Cem DATE OF BURIAL June 23, 193020 UNDERTAKER Wm. J. Ticknait & Son ADDRESS N + La. Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

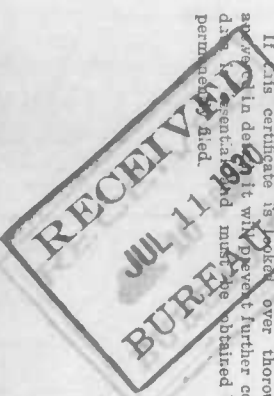
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Drepy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions asked in the directions are answered, it will prevent further correspondence. All the data presented must be obtained before the certificate is permanently filed.



WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PRINCIPALS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

10142

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 34Village or City Beckleyville (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Baby Hare

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>single</u>
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6 DATE OF BIRTH 9 8, 1930  
(Month) (Day) (Year)7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. ?  
If LESS than 1 day... hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) None9 BIRTHPLACE (State or country) Parkton Ind10 NAME OF FATHER George H Hare11 BIRTHPLACE OF FATHER (State or country) Hampstead Ind12 MAIDEN NAME OF MOTHER Noomi Skidd13 BIRTHPLACE OF MOTHER (State or country) Parkton Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George H. Hare  
(Address) Parkton Ind15 Filed Sept 8 1930 G. E. Fawth M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 8, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192\_\_\_\_, to \_\_\_\_\_, 192\_\_\_\_  
that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_.

The CAUSE OF DEATH was as follows:

Still Born  
(Duration) 0 yrs. 0 mos. 0 ds.Contributory  
Secondary(Signed) S. M. Rosh M.D.  
(Address) Hampstead Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence, \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Middle Town cemetery DATE OF BURIAL Sept 9th, 193020 UNDERTAKER R. Trasher ADDRESS Freeland Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Typhoid fever" (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds*; *Bronchopneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 2 1930  
BUREAU

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			01384		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Balto</u>			90 <u>7</u>		Registration Dist. No. <u>30</u>	
Village or City <u>Catonsville</u> (No. <u>1</u> )			St. <u>Mad</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary J. Hargrove</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Caucas</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>				
6 DATE OF BIRTH <u>Nov 15</u> , 1871 (Month) (Day) (Year)						
7 AGE <u>58</u> yrs. <u>2</u> mos. <u>20</u> ds. or LESS than 1 day ____ hrs. ____ min.						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House Work</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Maid</u>						
9 BIRTHPLACE (State or country) <u>Va.</u>						
PARENTS	10 NAME OF FATHER <u>Hiram Conway</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>					
	12 MAIDEN NAME OF MOTHER <u>Sarah Derby</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Va.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Rosa Flournoy</u>						
(Address) <u>1422 W. Guilford</u>						
15 Filed <u>7/6</u>	<u>30</u>	<u>1930</u>	Registrar <u>John Toadwin</u>			
			19 PLACE OF BURIAL OR REMOVAL <u>Int. Burial</u>		DATE OF BURIAL <u>3/8</u> , 1930	
			20 UNDERTAKER <u>John Toadwin</u>		ADDRESS <u>Small Hill</u>	
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Feb. 5th</u> , 1930 (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>5</u> , 192 <u>3</u>						
that I last saw him alive on <u>Feb 5</u> , 192 <u>3</u>						
and that death occurred on the date stated above, at _____ in.						
The CAUSE OF DEATH * was as follows: <u>Obv. Dis. of Heart</u> (Duration) <u>7</u> yrs. ____ mos. ____ ds.						
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.						
(Signed) <u>Chas. T. McKeown</u> M. D. <u>Feb 5</u> , 1930 (Address) <u>Catonsville Md</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.						
Where was disease contracted, if not at place of death?						
Former or usual residence						

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

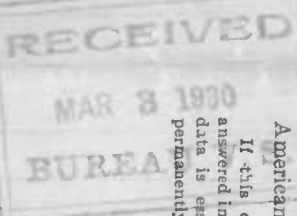
(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, vertebrae, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITING, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

14683

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Mt. Washington

(No.

Fall Road

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

premature female infant of Mr. &amp; Mrs. Harmon

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

✓

6 DATE OF BIRTH

December 16, 1920  
(Month) (Day) (Year)

7 AGE

premature about 6 mos.  
yrs. mos. ds.

if LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

✓

9 BIRTHPLACE

(State or country)

Baltimore Co. Md.

10 NAME OF FATHER

John M. Harmon

11 BIRTHPLACE OF FATHER

(State or country)

Mt. Washington Md.

12 MAIDEN NAME OF MOTHER

Laura Ray

13 BIRTHPLACE OF MOTHER

(State or country)

Howard Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. Harmon

(Address)

Mt. Washington Md.

15

Filed

Dec 17, 1920

J. P. Butcher

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 16, 1920  
Dead from (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191 , to , 191 ,

that I last saw him alive on , 191 ,

and that death occurred on the date stated above, at 6:05 pm

The CAUSE OF DEATH \* was as follows:

Premature birth 6 mos about gestation  
(Duration) yrs. mos. ds.

Contributory Secondary

not known  
(Duration) yrs. mos. ds.

(Signed)

William J. B. B. B.  
(Address) Baltimore Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore, Dec 17, 1920  
Baltimore, Dec 17, 1920

20 UNDERTAKER

ADDRESS

W. C. Brook &amp; Son Sparks Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonarum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal, septicaemia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling iron—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 8 1931  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

12194 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 244

Village or City Edgemoor Sparrows Point Md (No. 1) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Blanch B. Haring

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH January 11, 1873  
(Month) (Day) (Year)

7 AGE 57 yrs. 10 mos. 16 ds. or min. If LESS than 1 day hrs. min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Painter  
(b) General nature of industry, business, or establishment in which employed or (employer) Beth Steel Co Md

9 BIRTHPLACE (State or country) New York

10 NAME OF FATHER Garnett Haring

11 BIRTHPLACE OF FATHER (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (State or Country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Blanch Haring

(Address) Edgemoor Sparrows Point

15 Filed Oct 29 1930 H. H. Haring Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 27, 1930  
October (Month) 27 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 192 m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhages Caused by Automobile Accident

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

Acting Coroner (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Thomas R. Brannon M.D.

Oct 27 1920 (Address) R101348 Sparrows

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Larkwood Ceme Oct 30, 1930

20 UNDERTAKER

ADDRESS

H. H. Haring Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rencher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1920



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		06472 (31)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Mt. Wilson</u> (No. <u>Mt Wilson Branch</u> )		St. <u>Md. Tuberculosis Sanatorium</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Isabelle Harper</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>January 8, 1903</u> (Month) (Day) (Year)					
7 AGE <u>27</u> yrs. <u>5</u> mos. <u>17</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Harford Co. Md.</u>					
10 NAME OF FATHER <u>James Gallahan</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>					
12 MAIDEN NAME OF MOTHER <u>Mary Bodani</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Louis R. Schuerholz</u> (Address) <u>Mt Wilson Md.</u>					
15 Filed <u>June 25 1930</u> <u>D &amp; E Nichols</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 25, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 18, 1930</u> to <u>June 25, 1930</u> , that I last saw her alive on <u>June 24, 1930</u> , and that death occurred on the date stated above, at <u>4:05 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>One</u> yrs. <u>5</u> mos. <u>0</u> ds. Contributory <u>Tuberculosis of the Larynx</u> (Duration) <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds. (Signed) <u>John A. Smith</u> M. D. <u>June 25, 1930</u> (Address) <u>Mt. Wilson, Md.</u> * State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>7</u> ds. In the <u>2</u> State <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds. Where was disease contracted, if not at place of death? <u>2</u> Former or usual residence <u>Bel Air, Md.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>St Ignace Cemetery</u> DATE OF BURIAL <u>June 26, 1930</u>					
20 UNDERTAKER <u>Dean &amp; Feltz Bel Air, Md</u> ADDRESS					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Airedict, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poison d by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Calgate (No. 91)

2 FULL NAME Elice Lu Harris

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 41

St. 7th Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)  
6 DATE OF BIRTH May 24<sup>th</sup> 1930  
(Month) (Day) (Year)  
7 AGE 4 yrs. 4 mos. 4 ds. or 1 day 4 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balts Co. Md.  
10 NAME OF FATHER Eddie Harris  
11 BIRTHPLACE OF FATHER (State or country) Virginia  
12 MAIDEN NAME OF MOTHER Edith Clark  
13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Harris  
(Address) Calgate Md.

15 Filed Apr 9 1930 192 W. L. McNamee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 28<sup>th</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 11 m.

The CAUSE OF DEATH \* was as follows:

Unknown  
Dr. Cassius W. Greenhut  
Well, at bedtime. Found dead in bed, in morn-  
(Duration) 1 day 4 min.?

Contributory  
Secondary

(Signed) Frederick B. Adams (Address) Dundalk Md.  
Sept 28 1930

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 4 mos. 4 ds. In the State 1 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stbury Cr

Sept 29, 1930

20 UNDERTAKER

ADDRESS

W. L. Brown

Balto.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1, 1930

Dr. Cassius W. Greenhut May 98

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident, Revolver wound of head—homicide, Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 2 1930

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1 PLACE OF DEATH  
County Baltimore

Village or City W. Fowlesburg (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Infant - Harris

02629 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 23, 1930  
(Month) (Day) (Year)

7 AGE Still born It LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?  
yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8 OCCUPATION (a) Trade, profession, or particular kind of work none  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS  
10 NAME OF FATHER Howard Harris  
11 BIRTHPLACE OF FATHER (State or country) Carroll Co., Md.  
12 MAIDEN NAME OF MOTHER Helen Marie Bosley  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Harris  
(Address) Upperco, Md.

15 Filed 3-24<sup>th</sup> 1930 Mrs. Joshua A. Fowle  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930 to March 23, 1930  
that I last saw him alive on March 23, 1930  
and that death occurred on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH \* was as follows:

Still Born  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary  
(Signed) April E. Fowle M. D.  
March 23, 1930 (Address) Upperco Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted,  
If not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St Pauls. DATE OF BURIAL 3-24, 1930

20 UNDERTAKER Edw A Tipton ADDRESS Hampstead Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

07697

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 52

Village or City Mount Wilson (No. Mount Wilson Branch St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
<sup>2</sup> FULL NAME Robert Marion Harrison

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Male <sup>4</sup> COLOR OR RACE White <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

<sup>6</sup> DATE OF BIRTH April 15, 1897  
(Month) (Day) (Year)

<sup>7</sup> AGE 33 yrs. 3 mos. 5 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

<sup>8</sup> OCCUPATION  
(a) Trade, profession or particular kind of work Interior Decorator  
(b) General nature of industry, business, or establishment in which employed or (employer)

<sup>9</sup> BIRTHPLACE (State or country) Maryland

<sup>10</sup> NAME OF FATHER William H. Harrison

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Maryland

<sup>12</sup> MAIDEN NAME OF MOTHER Estelle Mason

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Maryland

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary H. Harrison

(Address) 1918 N. Payson St. Balto.

<sup>15</sup> Filed July 21, 1930 D. E. W. W. W. Registrar

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH July 20, 1930  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended the deceased from June 18, 1930 to July 20, 1930, that I last saw him alive on July 20, 1930, and that death occurred on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH \* was as follows:

Pulmonary and Intestinal Tuberculosis  
(Duration) 11 yrs. 11 mos. 3 ds.

Contributory Spontaneous Pneumothorax  
Secondary (Duration) 0 yrs. 2 mos. 23 ds.

(Signed) John A. Smith M. D.  
July 20, 1930 (Address) Mount Wilson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

<sup>18</sup> LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 1 mos. 2 ds. In the 33 yrs. 3 mos. 5 ds. State 7

Where was disease contracted, if not at place of death?

Former or usual residence 1918 N. Payson St. Balto. Md.

<sup>19</sup> PLACE OF BURIAL OR REMOVAL New. Cathedral Cemetery DATE OF BURIAL July 24, 1930

<sup>20</sup> UNDERTAKER L. W. Conklin ADDRESS 24 E. Egan St.

9-11 20.2.8  
Wm E. C. Michaelis

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 2 1930  
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore0181 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William B Harrison

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH  
Jan 25, 1868  
(Month) (Day) (Year)7 AGE  
62 yrs. 0 mos. 1 ds. or 1 day 1 hrs. 1 min.?  
If LESS than 1 day8 OCCUPATION  
(a) Trade, profession or particular kind of work Yard Foreman  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Thomas H Harrison11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Margaret Harrison13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Hospital Records--Personal History  
(Informant)Eudowood Sanatorium, Towson, Md.  
(Address)15 Filed Jan 26, 1930 Wm P. Butler  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Jan 26, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Nov 9, 1929 to Jan 26, 1930that I last saw him alive on Jan 26, 1930and that death occurred on the date stated above, at 2:25 p.m.

The CAUSE OF DEATH \* was as follows:

Pulmonary TuberculosisAlmt. (Duration) 1 yrs. 0 mos. 0 ds.Contributory  
Secondary(Duration) 1 yrs. 0 mos. 0 ds.(Signed) W A Bridges M. D.Jan 26, 1930 (Address) Towson, Maryland

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recant Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence 3907 Norfolk Ave (Forest Park)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Goodlown Cem Jan 30, 1930

20 UNDERTAKER

ADDRESS

W A Bridges 242

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal Fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Prosepy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 8 1930  
BUREAU V-8



WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

06473

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

30

Village or City

Catonville

(No.

Sleuca an

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Female child of Robt H + Anna Harrison

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

June 1, 1930  
(Month) (Day) (Year)

7 AGE

11 hours

If LESS than 1 day hrs. or min.?

yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Robt H Harrison

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Anna Adrian

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt H Harrison

(Address)

Catonville Md

15

Filed

6/2

192

30

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 1, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

June 1, 19230 to June 1, 19230

that I last saw her alive on June 1, 19230

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH \* was as follows:

7 mos in Utero

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Marshall B West M. D.

June 2, 19230 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park June 2, 1930

20 UNDERTAKER

ADDRESS

Easton Sons Ellisville City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUL 11 1911  
BUREAU OF VITALS

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PARENTS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

0182

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 38 43

Village or City Fullerton P.D. (No. Richard & Baker Ave. SE. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William Henry Hartman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Oct. 8 1858  
(Month) (Day) (Year)

7 AGE 71 yrs. 3 mos. 12 ds. If LESS than 1 day, hrs. min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Plumber  
(b) General nature of industry business, or establishment in which employed or (employer) Retired

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Gottlieb Hartman

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Cheeter

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Hartman, Jr.  
(Address) Fullerton P.D.

15 Filed 1/21 1930 H. A. Futz  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 20 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from about 1924 to July 1929

that I last saw him alive on July 1929, and that death occurred on the date stated above at 7 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic myocarditis  
Chr. interstitial nephritis  
over 5 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) A. M. Bacon M. D.  
1/20 1930 Address Parkville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Trinity Cemetery DATE OF BURIAL 1/24 1930

20 UNDERTAKER Wm Cook ADDRESS 12175+ Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis")*; *Diphtheria (avoid use of "Croup")*; *Typhoid fever (never report "Typhoid Pneumonia")*; *Lobar pneumonia*, *Bronchopneumonia*, ("Pneumonia,"

1858  
11  
1929

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 8 1900  
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

01385

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

Village or City

English Consul Amagata Rd

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Elizabeth Z Hauck

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

widowed

6 DATE OF BIRTH

May 29, 1859  
(Month) (Day) (Year)

7 AGE

70 yrs. 8 mos. 15 ds. or min.?

If LESS than  
1 day.....hrs.  
or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

house

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Balt. Md.

10 NAME OF FATHER

Judeus Raschke

11 BIRTHPLACE OF FATHER  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER  
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elon J Hauck

(Address)

English Consul

15

Filed

July 14 1930

Ger M Kieffer

Resident

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July 10, 1930 to July 12, 1930

that I last saw her alive on July 12, 1930

and that death occurred on the date stated above, at 8 PM

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

Contributory  
Secondary

Myocardial Degeneration

(Signed)

Dr. M. Kieffer M. D.

July 13, 1930 (Address) 42 Federal

\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

Hauck's Burial July 16, 1930

20 UNDERTAKER

Ernest Armstrong Steeney

ADDRESS

Flight near Heurich



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Sedesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia,"

MAR 4 1930  
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesenteric Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesenteric disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *septicaemia*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

WRITE FINGERPRINTS WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Balto.

1087323

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City

Middle River Bull Neck

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Francis Gary

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Sept 27, 1930  
(Month) (Day) (Year)

7 AGE

yrs. mos. ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Essex, Md.

10 NAME OF  
FATHER

Louis J. Trauf.

11 BIRTHPLACE  
OF FATHER

(State or country)

Balto. Md.

12 MAIDEN NAME  
OF MOTHER

Kathleen Van Norman

13 BIRTHPLACE  
OF MOTHER

(State or country)

Laconia Wash.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George G. Trauf.

(Address)

15 P. Smallwood St

15

Filed Oct. 2, 1930

John S. Connelley

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 27, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Sept 27, 1930 to Sept 27, 1930  
that I last saw him alive on Sept 27, 1930

and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH \* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. White M. D.  
Sept 28, 1930 (Address) Essex Md\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto Cemetery Oct 3, 1930

20 UNDERTAKER

ADDRESS

A. A. Krause &amp; Son 703 Hanover

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, to fix the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solomon, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

Fred A. Moore  
703 Hammond St  
Beaumont

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930  
BUREAU

WRITE PARENTS WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHOTOCOPIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City Middle River (No. Bull neck) St. 44 Ward 44 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Louis Kauf, Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Sept 27, 1930  
(Month) (Day) (Year)

7 AGE 1 day 1 hrs. 1 min. 1 sec. (If LESS than 1 day, write hrs. or min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Essex Md.

10 NAME OF FATHER Louis J. Kauf.

11 BIRTHPLACE OF FATHER (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Kathleen Van Norman

13 BIRTHPLACE OF MOTHER (State or country) Tacoma, Wash.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George A. Kauf.

(Address) 1500 Smallwood

15 Filed Oct. 2, 1930 John S. Connolly  
Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 27, 1930 to Sept 27, 1930.

that I last saw him alive on Sept 27, 1930.

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:

Stillborn  
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) L. F. White M. D.

9/28, 1930 (Address) Essex Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Balto Cemetery Oct 3, 1930

20 UNDERTAKER ADDRESS

F.A. Aranae & Son 703 Hanover

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laboree," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia," *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A third and is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## PLACE OF DEATH

County

*Baltimore*

Village or City

*Rockyville*

(No.)

2 FULL NAME

*Barroll Hawn*

12195

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

38

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Married*

6 DATE OF BIRTH

*Oct 20, 1898*  
(Month) (Day) (Year)

7 AGE

*32<sup>31</sup> yrs. 11 mos. 17 ds.*  
If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work *Fisherman on Steamer*  
(b) General nature of industry, business, or establishment in which employed or (employer) *shovel*

9 BIRTHPLACE (State or country)

*Maryland*

10 NAME OF FATHER

*Edward Hawn*

11 BIRTHPLACE OF FATHER (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Lillian G. Francis*

13 BIRTHPLACE OF MOTHER (State or Country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Eagle W. Hawn*

(Address)

*Westminster Md*

15

Filed

*Oct 7 1920**W. P. Butler*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Oct 7, 1920*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

*Accidental*  
*Head run over by a truck on the road from Pikesburg to White Hall*  
(Duration) yrs. mos. ds.

Contributory Secondary

(Signed) *W. P. Butler* (Coroner) M. D.  
*Oct 7 1920* (Address) *Towson, Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Uniontown Carroll Co**Oct 7, 1920*

20 UNDERTAKER

ADDRESS

*Francis Reese**Westminster, Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archdeacon, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Caul mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Baltimore*

08968

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*30*

Village or City

*Catonsville* (No. *Wentworth*)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Sabella Hayes*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Colored*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Married*

6 DATE OF BIRTH

*June 18th 1904*  
(Month) (Day) (Year)

7 AGE

*56* yrs. *2* mos. *1* ds. or min.?  
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

*Housewife*

9 BIRTHPLACE

(State or country)

*Columbia Howard Co. Md.*

10 NAME OF FATHER

*James A. Sands*

11 BIRTHPLACE OF FATHER

(State or country)

*Howard Co. Md.*

12 MAIDEN NAME OF MOTHER

*Sarah Brown*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Howard Co.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Benjamin Hayes*

(Address)

*Catonsville*

15

Filed

*8/23*

192

*30**Blanch*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*August 19th 1923*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*July 30th 1923* to *August 19th 1923*that I last saw him alive on *August 18th 1923*and that death occurred on the date stated above, at *7:19* m.

The CAUSE OF DEATH \* was as follows:

*Pneumonia*  
(Duration) *10* yrs. *10* mos. *10* ds.Contributory  
Secondary(Duration) *10* yrs. *10* mos. *10* ds.

(Signed)

*John F. Alexander* M. D.*1923* (Address) *1400*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *10* yrs. *10* mos. *10* ds.In the State *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bush Park Co. Aug 23, 1923*

20 UNDERTAKER

ADDRESS

*Blanch I. Skensley* *178*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever*, (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

07698

## CERTIFICATE OF DEATH (31)

1—PLACE OF DEATH

Emory Grove

REGISTERED NO. 33

CITY OF BALTIMORE: (No.

ST.,

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME

Anna P. Heath

(a) RESIDENCE NO.

Emory Grove

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds.

How long in U. S., if foreign birth? yrs. — mos. — ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)  
divorced5a If married, widowed, or divorced  
HUSBAND of.  
(or) WIFE of.

6 DATE OF BIRTH (month, day, and year)

Jan 25, 1877

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

53

— 5

— 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

Dover, N. H.

10 NAME OF FATHER

Frank Freeman

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

New Hampshire

12 MAIDEN NAME OF MOTHER

Jane?

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

New Hampshire

14

Informant  
(Address)Mrs. Carita Wentworth  
Emory Grove

15

Filed

July 2, 1930

H. M. State

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 1, 1930

17

HEREBY CERTIFY, That I attended deceased from  
May 15, 1930, to May 18, 1930,  
that I last saw her alive on May 30, 1930,  
and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. at least

CONTRIBUTORY  
(Secondary)

manition

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted  
if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray of chest

(Signed) M. L. Small, M. D.

7/2, 1930 (Address) 18 West Read St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

Green New Hamph

DATE OF BURIAL

7/3 1930

20 UNDERTAKER

Robert Brooks &amp; Son

ADDRESS

Cathlamet  
Health

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state EXACTLY. Exact statement of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As theia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

## ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN

Skin patient was not seen by me after death. The time of death as stated in certificate was given by Dr. Price, Hynden, Md.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PARTICULARS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

0183

Wittow 310 Highland St.  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 4

Village or City Sundalk (No. ....)

St. .... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Samuel T. Heath

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

May 20, 1976  
(Month) (Day) (Year)

7 AGE

53 yrs. 8 mos. 8 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Watchman

(b) General nature of industry, business, or establishment in which employed or (employer)

Ship. mtds.

9 BIRTHPLACE (State or country)

Baltimore

10 NAME OF FATHER

Mr. - Known

11 BIRTHPLACE OF FATHER (State or country)

Mr. - Known

12 MAIDEN NAME OF MOTHER

Mr. - Known

13 BIRTHPLACE OF MOTHER (State or Country)

Mr. - Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ida Lawson

(Address) 21 Sunshine Road

15

Filed 1/20/30 1930

Wm. C. ...  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 20, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Feb 1, 1929 to Jan 20, 1930

that I last saw him alive on Jan 18, 1930

and that death occurred on the date stated above, at 4-30 A.M.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis

Contributory Secondary

(Duration) Gradual yrs. mos. ds.  
Chronic Myocarditis  
(Duration) Gradual yrs. mos. ds.

(Signed) Harace B. Wittow M. D.

Jan 20, 1930 (Address) 315 S. Highland Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds.

In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Olivet Jan 23, 1930

20 UNDERTAKER

ADDRESS

Wm. C. ... 1217 St. Paul

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

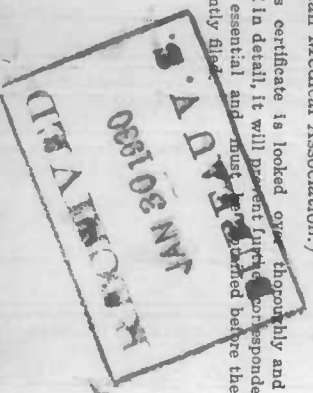
**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "Puerperal peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING  
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.07689 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Cessey (No. 103)Horsley Ave. St. 185 Ward 1 (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Adolph Heck

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)6 DATE OF BIRTH Jan 10, 1882  
(Month) (Day) (Year)7 AGE 78 yrs. 6 mos. 15 ds. or 1 day hrs. min.?  
If LESS than 1 day8 OCCUPATION  
(a) Trade, profession or particular kind of work Butcher  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Balto. Md.10 NAME OF FATHER H. M. Heck11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Clara Anna Cuddeheight13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Heck  
(Address) Horsley Ave.15 Filed July 28 1920 John G. Connelly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 22, 1920 to July 25, 1920, that I last saw him alive on July 25, 1920, and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH \* was as follows:

Fracture of spine. patient fell down a flight of stairs. Aug 30.  
(Duration) 2 yrs. 2 mos. 2 ds.Contributory  
Secondary(Signed) James J. White M. D.  
July 28 1920 (Address) Cessey, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL July 28, 192020 UNDERTAKER John G. Connelly ADDRESS Cessey

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

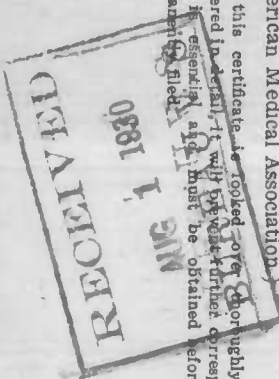
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will be quite sufficient correspondence. All the data are essential and must be obtained before the certificate is permanently filed.







# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE AGAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore  
Spring Grove State Hospital

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Christina Helfenbein

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

widow

6 DATE OF BIRTH

Date of birth month & day 1852  
unknown (Month) (Day) (Year)

7 AGE

78 yrs.

mos.

ds.

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

House work

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Andrew Schmidt

11 BIRTHPLACE OF FATHER

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

son - Chris. Helfenbein  
1620 Clinton St

15

Filed

7/18 192

192

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1st 1930 to July 17, 1930

that I last saw her alive on July 17, 1930

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic nephritis

Contributory Secondary

(Duration) 10 yrs. mos. ds.

Arterio-sclerosis

(Duration) 10 yrs. mos. ds.

(Signed) Arthur L. Wright M. D.

July 17, 1930 Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 26 yrs. 11 mos. 30 ds. In the unknown State yrs. mos. ds.

Where was disease contracted, at place of death, if not at place of death?

Former or usual residence Baltimore City

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Matthews

July 20, 1930

20 UNDERTAKER

ADDRESS

John Welch

2008 Orleans

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

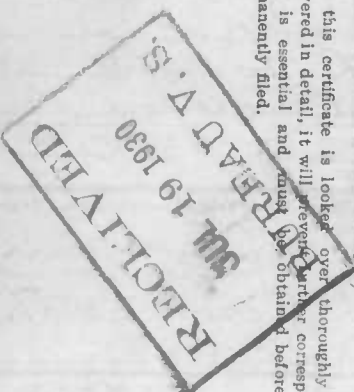
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc.* (*Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; whooping pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Texas

00892

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 37

Village or City

Cockeysville

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Geo. Felt

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

unknown

1853

(Month)

(Day)

(Year)

7 AGE

about

77

yrs.

mos.

ds.

IF LESS than

1 day.....hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF

FATHER

unknown

11 BIRTHPLACE

OF FATHER

(State or country)

unknown

12 MAIDEN NAME

OF MOTHER

unknown

13 BIRTHPLACE

OF MOTHER

(State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alonso Home Record

(Address)

Texas and

15

Filed

Jan 12 1930

B. B. Bennett

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 12, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 27

to Jan 12

1930

that I last saw him alive on

Jan 10

1930

and that death occurred on the date stated above, at 12:40 P. M.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
Intermittent Myocarditis

(Duration) 2 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

B. B. Bennett

M. D.

Jan 12 1930 (Address) Cockeysville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mrs. Olive Emery

Jan 14, 1930

20 UNDERTAKER

ADDRESS

W. E. Barker

Sparkswood



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet fever* (never report "Scarlet Pneumonia"); *Scarlet pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Hysteria," "Insanity," "Mania," "Marasmus," "Old Age," "Shock," "Tetanus," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 5 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

01386

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(129)

Registration Dist. No. 30

Village or City Catonville Spring Grove Hosp (No. ---) (Ward) ---

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Rebecca Helwig

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH May 11, 1867  
(Month) (Day) (Year)

7 AGE 62 yrs. 8 mos. 28 ds. or --- min. If LESS than 1 day --- hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) ---

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jas. Martin

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Margaret Sewall

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harman Helwig  
(Address) 2431 Washington Pl

15 Filed Feb 9 1930 C. L. Haffett  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 14, 1927 to Feb 9, 1930  
that I last saw her alive on Feb 8, 1930

and that death occurred on the date stated above, at 10:30 p.m.  
The CAUSE OF DEATH \* was as follows:

Chr. Interstitial Nephritis  
(Duration) 1 yrs. --- mos. --- ds.

Contributory Arterio-Sclerosis  
Secondary (Duration) 1 yrs. --- mos. --- ds.

(Signed) Robt. E. Garrett M. D.  
Feb 9 1930 (Address) Catonville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 6 mos. 26 ds. In the 62 yrs. 8 mos. 28 ds. State

Where was disease contracted at place of death  
it not at place of death ---

Former or usual residence Balto. Md

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Pauls Rectory Feb 12 1930

20 UNDERTAKER ADDRESS

For Founders Son 207 S. Bay

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions worked in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1890  
BUREAU

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## 1 PLACE OF DEATH

County Balto County

06474

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 45Village or City Chase Ind. (No. 129) E. Sawyer Road. St.; Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Catherine Kesslein

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, Married

WIDOWED

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

Apr. 8, 1871  
(Month) (Day) (Year)

7 AGE

58 yrs. 6 mos. 26 ds. or 1 day 1 hr. 5 min. ?If LESS than  
1 day....hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of workHousewife(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Harford County10 NAME OF  
FATHERPatrick Foley11 BIRTHPLACE  
OF FATHER

(State or country)

Ireland12 MAIDEN NAME  
OF MOTHERSmith13 BIRTHPLACE  
OF MOTHER

(State or country)

Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George W. Kesslein(Address) E. Sawyer Rd. Chase Ind.

15

Filed June 4, 1930 John V. Ormally  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 3, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

24. 1st 1930, to June 3, 1930.that I last saw her alive on June 3, 1930.and that death occurred on the date stated above, at 11 pm.

The CAUSE OF DEATH it was as follows:

Chronic Nephritis  
Chronic Interstitial Nephritis(Duration) 1 yrs. 0 mos. 0 ds.Contributory  
Secondary(Duration) 1 yrs. 0 mos. 0 ds.(Signed) James F. White M.D.June 4, 1930 (Address) Box 5, Md.\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury; and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents)At place of death 0 yrs. 0 mos. 0 ds. In the State, 0 yrs. 0 mos. 0 ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parkwood Cemetery June 6, 1930

20 UNDERTAKER

ADDRESS

Mrs. G. Miller & Son 2334 Jefferson St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Coronary arterial fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 40 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 7 1930  
BUREAU V



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		02630		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Cockeysville</u> (No. _____)		(161-0)		Registration Dist. No. <u>37</u>	
2 FULL NAME <u>Ethel R Henry</u>		St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>			
6 DATE OF BIRTH <u>February 19, 1920</u> (Month) (Day) (Year)					
7 AGE <u>17</u> yrs. <u>17</u> mos. <u>17</u> ds. or <u>17</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>md</u>					
10 NAME OF FATHER <u>Robert F. Henry</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>md</u>					
12 MAIDEN NAME OF MOTHER <u>Ethel Henry</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ethel Henry</u> (Address) <u>Cockeysville</u>					
15 Filed <u>May 7, 1920</u> <u>R. B. Beman</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 6, 1920</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 19, 1920</u> to <u>Mar 6, 1920</u> , that I last saw him alive on <u>Mar 5, 1920</u> , and that death occurred on the date stated above, at <u>11 A. m.</u> The CAUSE OF DEATH * was as follows: <u>Pneumonia</u> (Duration) _____ yrs. _____ mos. <u>17</u> ds.					
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>R. B. Beman</u> M. D. <u>Mar 7, 1920</u> (Address) <u>Cockeysville, Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Ridge Cemetery</u>				DATE OF BURIAL <u>March 7, 1920</u>	
20 UNDERTAKER <u>W. C. Beman</u>				ADDRESS <u>Springfield Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saretoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 4 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City St George (No. 129)

2 FULL NAME Charles T. Hyaley

10144 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

St. MD Ward 1 (if death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED widow  
(Write the word)

6 DATE OF BIRTH Sept 8, 1847  
(Month) (Day) (Year)

7 AGE 82 yrs. 11 mos. 28 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Hyaley

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Gunt

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Alverta Gore

(Address) Restertown MD

15 Filed Sept 7 19230 17mbl  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 6, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 15 19230 to Sept 6 19230

that I last saw him alive on Sept 7, 19230

and that death occurred on the date stated above, at 630 P m.  
The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

(Duration) 18 yrs. 18 mos. ds.

Contributory  
Secondary

(Duration) 18 yrs. 18 mos. ds.

(Signed) H. M. Smith M. D.

Sept 7 19230 (Address) Restertown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 18 yrs. 18 mos. ds. In the State 18 yrs. 18 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

David Ridge Cemetery Sept 7, 19230

20 UNDERTAKER ADDRESS

J. F. Ehrie Restertown MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

22

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

07761

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 938Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St.: \_\_\_\_\_ Ward: \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William May Herald

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>m</u>	4 COLOR OR RACE <u>w</u>	5 SINGLE, <input checked="" type="checkbox"/> MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> OR DIVORCED, <input type="checkbox"/> (Write the word)
-------------------	-----------------------------	--

6 DATE OF BIRTH <u>Sept. 13, 1908</u> (Month) (Day) (Year)
--

7 AGE <u>21</u> yrs. <u>10</u> mos. <u>16</u> ds. or min.?	IF LESS than 1 day... hrs. or... min.?
---	--

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)	<u>Electrician</u>
---	--------------------

9 BIRTHPLACE (State or country)	<u>Hyattsville, Md.</u>
------------------------------------	-------------------------

PARENTS	10 NAME OF FATHER <u>Henry Herald</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>
	12 MAIDEN NAME OF MOTHER <u>Louise Zimmerman</u>
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records--Personal History  
(Informant)

Eudowood Sanatorium, Towson, Md.

(Address)

15 Filed <u>July 29, 1930</u>	<u>W. P. Paul</u> Registrar
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>July 29, 1930</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from  
April 12, 1930 to July 7, 1930  
that I last saw him alive on July 24, 1930,  
and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH \* was as follows:

Pulmonary & Intestinal tuberculosis  
(Duration) 3 yrs. 7 mos. 7 ds.

Contributory  
Secondary

(Signed) W. A. Bridges M. D.  
180 (Address) Towson, Maryland.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.	In the State yrs. mos. ds.
------------------------------------	-------------------------------

Where was disease contracted, if not at place of death? Unknown

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

<u>Landon, Md.</u>	<u>July 30, 1930</u>
--------------------	----------------------

20 UNDERTAKER

ADDRESS

<u>439 Eppon St. Balt.</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Edmond (No. 1114 Overbrook St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

2 FULL NAME Heichert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH March 10th, 1930  
(Month) (Day) (Year)

7 AGE 5 1/2 yrs. 6 mos. 1 day 2 hrs. 0 min.  
IF LESS than 1 day 2 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Balto - Co. Md.

10 NAME OF FATHER John A. Herbert

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ruth E. Brooks

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Herbert

(Address) 1114 Overbrook Rd.

15 Filed Mar 10 1930 John P. Gutter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 10th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 10th, 1930 to March 10th, 1930, that I last saw him alive on March 10th, 1930

and that death occurred on the date stated above, at 5 A. m. The CAUSE OF DEATH \* was as follows:

5 1/2 months gestation  
(Duration) 5 1/2 mos. 0 ds.

Contributory  
Secondary

(Signed) Michael M. M. D.  
March 10th, 1930 (Address) 3005 E. Main St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mar 10, 1930

20 UNDERTAKER

ADDRESS Edmond

Parents 1114 Overbrook Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory, The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Tortionaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rencher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

Village or City

Catonville Spring Grove HospitalRegistration Dist. No. 30STATE OF MARYLAND  
CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Elizabeth Hergenrother

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)widow

6 DATE OF BIRTH

November 3<sup>rd</sup>, 1874  
(Month) (Day) (Year)

7 AGE

56 yrs. 0 mos. 14 ds.  
If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

clerk of Hotel keeper

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Joseph Weber

11 BIRTHPLACE OF FATHER

(State or country)

France

12 MAIDEN NAME OF MOTHER

Maggie Boyd

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos. Hergenrother

(Address)

Harve de Grace

15

Filed

11/19 1930Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 18<sup>th</sup>, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 21 1925 to Nov 18<sup>th</sup>, 1930.that I last saw her alive on Nov 17<sup>th</sup>, 1930and that death occurred on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH \* was as follows:

Acute Cardiac dilatation

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
SecondaryMyocarditis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Robt. E. Garrett M. D.Nov 19 1930 (Address) Catonville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 14 yrs. 11 mos. 26 ds. In the State 5 yrs. 0 mos. 14 ds.Where was disease contracted, Yes at place of death if not at place of death?Former or usual residence Harve de Grace Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Elm CemNov 21, 1930

20 UNDERTAKER

ADDRESS

J. & Pennington & Son De Grace Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
 Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
 County Baltimore

Village or City Parton (No. \_\_\_\_\_)

2 FULL NAME Delores Del Rio Herman

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 85

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)

6 DATE OF BIRTH January 15, 1930  
 (Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 yrs. 6 mos. 1 ds. or \_\_\_\_\_ min.

8 OCCUPATION  
 (a) Trade, profession or particular kind of work none  
 (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Clarence Herman

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laveria Snyder

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Herman  
 (Address) Parton, Md.

15 Filed July 19, 1930 M. B. B. M. D.  
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1930  
 (Month) 17 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 11, 1930 to July 17, 1930  
 that I last saw her alive on July 16, 1930

and that death occurred on the date stated above, at 12:20 p.m.  
 The CAUSE OF DEATH \* was as follows:

Whooping cough

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.  
 Contributory Secondary convulsions due to  
asphyxia

(Signed) Gilbert L. Hesser M. D.  
July 17, 1930 (Address) White Hall Md.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL E. Leroy Stiffler DATE OF BURIAL July 19, 1930

20 UNDERTAKER St. Zion, Freedland ADDRESS 125 E. North Ave  
Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 9 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City 601 Anneslie Road

2 FULL NAME Lucretia L. Herschner

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 3, 1847  
(Month) (Day) (Year)

7 AGE 82 yrs. 8 mos. 1 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer) -

9 BIRTHPLACE (State or country) Balto. Co. Md.

10 NAME OF FATHER Joseph Seitz

11 BIRTHPLACE OF FATHER (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (State or Country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Amy Baker

(Address) 601-Anneslie Road

15 Filed Mar 5 - 1930 Thos. Butler, Jr. Registrar

02632

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

St.: \_\_\_\_\_ Ward: \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 26, 1930 to March 4, 1930, that I last saw her alive on March 4, 1930,

and that death occurred on the date stated above, at 8:50 A. M.

The CAUSE OF DEATH \* was as follows:

Chronic valvular heart disease

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Carl H. Benson M. D.  
March 4, 1930 (Address) 5111 York Rd.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
M. E. Cune. Cemetery Mar 6, 1930

20 UNDERTAKER ADDRESS  
John Benson Sons Towson

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930  
BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Ellicott City, Md. (No. 9P)

2 FULL NAME Rachel V. Hewitt

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 18, 184  
(Month) (Day) (Year)

7 AGE 66 yrs. 4 mos. 18 ds. or 18 min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William L. Roth

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Elliott

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam S. Hewitt  
(Address) Ellicott City, Md.

15 Filed 11/7 1930 Blindman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1, 1924 to Nov 5, 1930  
that I last saw him alive on Nov 5, 1930

and that death occurred on the date stated above, at 11:15 P. m.  
The CAUSE OF DEATH \* was as follows:

Arterio-sclerosis  
(Duration) 4 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) W. J. Dorman M. D.  
Nov 6, 1930 (Address) Ellicott City, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Johns Cem. DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Baltimore*

14684

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *31*Village or City *Woodlawn* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Annie E. Hickey*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*7*

4 COLOR OR RACE

*whit*

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

*married*

6 DATE OF BIRTH

*SEP**10**1883*

(Month)

(Day)

(Year)

7 AGE

*47* yrs.

— mos.

*21* ds.

If LESS than

1 day \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*House wife*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Ind*

10 NAME OF FATHER

*John A. Suen*

11 BIRTHPLACE OF FATHER

*Ind*

(State or country)

12 MAIDEN NAME OF MOTHER

*Sarah E. Bryant*

13 BIRTHPLACE OF MOTHER

*S. C.*

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Wm. Hickey*

(Address)

*Woodlawn Ind*

15

Filed

*SEP 31**1930**H. F. Shupley*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*SEP**31**1930*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*SEP 1**1929*

to

*SEP 31**1930*that I last saw him alive on *SEP 30*, *1930*,and that death occurred on the date stated above, at *119* m.

The CAUSE OF DEATH \* was as follows:

*Diabetic Sanguine of P. H. G.*

(Duration)

yrs.

mos.

*10* ds.Contributory  
Secondary*Diabetes*

(Duration)

yrs.

mos.

*4* yrs.

(Signed)

*Sam F. Shupley*

M. D.

*SEP 31**1930*

(Address)

*Woodlawn Ind*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the

State

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Alberta, Catholic Cem**Jan 3, 1931*

20 UNDERTAKER

ADDRESS

*Eaton Sons**Ellicott City*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *shop pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 2 1931

BUREAU V.

H. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

14685

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

37

Village or City

near Phoenix

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Walter Hickman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Feb 28

1907

(Month)

(Day)

(Year)

7 AGE

23

yrs.

mos.

ds.

If LESS than  
1 day.... hrs.

or.... min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

West Va.

10 NAME OF FATHER

Iser. Hickman

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

Bell Spray

13 BIRTHPLACE OF MOTHER

(State or country)

West Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lynn Maynard

(Address)

Jobe Kentucky

15

Filed

Dec 6 1930 B. B. Bennett

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 6

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192

to

192

that I last saw him

alive on

192

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Internal hemorrhage  
brushed across the chest by  
pipe falling on him in ditch

(Duration)

yrs.

mos.

da.

Contributory

Secondary

(Duration)

yrs.

mos.

da.

(Signed)

W. P. Smith (Coroner)

M. D.

Dec 6

1920

(Address)

Lawson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

da.

In the State,

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Maynard Cem.

Dec 6 1930

20 UNDERTAKER

ADDRESS

John Burns Sons Towson Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary). *Id.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmic," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JAN 8 1931  
BUREAU



1 PLACE OF DEATH

County

Baltimore

08487

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

30

Village or City

Catonville Spring Grove Hospital

(No.)

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Edward M. Hickok Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 30, 1907

(Month)

(Day)

(Year)

7 AGE

23 yrs. 0 mos. 0 ds. or min.?

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Illinois

10 NAME OF  
FATHER

Edward M. Hickok Sr.

11 BIRTHPLACE  
OF FATHER

(State or country)

Mich.

12 MAIDEN NAME  
OF MOTHER

Susan Payne

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Mich.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Hickok Sr.

(Address)

3706 N. Charles St.

15

Filed

7/31 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 30, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Mich 12 1920 to July 30, 1930

that I last saw him alive on July 30, 1930

and that death occurred on the date stated above, at 4 P. m.  
The CAUSE OF DEATH \* was as follows:

Pericious Anaemia

(Duration) 1 yrs. mos. ds.

Contributory  
Secondary

Manic Depressive Psychosis

(Duration) yrs. 6 mos. ds.

(Signed) Robt E. Garner M. D.

July 30, 1930 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 4 mos. 18 ds. In the 2 State yrs. mos. ds.

Where was disease contracted at place of death it not at place of death?

Former or usual residence Baltimore Md.

19 PLACE OF BURIAL OR REMOVAL

London Ok. Cem

DATE OF BURIAL

8/1, 1930

20 UNDERTAKER

Harry R. Witzke, 4101 Edmondson Ave.

ADDRESS

If more blanks are needed, address State Registrar, 16 W. State St., Balto., requesting V. S. No. 1.

WRITE AGAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
SEP 10 1904  
BUREAU OF  
VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

08488

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 31

Village or City Woodlawn No. 129 W. Alto Ave St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME A. Howard Heatzman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH March 30, 1861  
(Month) (Day) (Year)

7 AGE 69 yrs. 3 mos. 25 ds. or 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Butcher  
(b) General nature of industry, business, or establishment in which employed or (employer) Self

9 BIRTHPLACE (State or country) Balto Md

10 NAME OF FATHER Matthias Heatzman

11 BIRTHPLACE OF FATHER (State or country) city

12 MAIDEN NAME OF MOTHER Margaret Poole

13 BIRTHPLACE OF MOTHER (State or Country) city

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Evelyn Heatzman  
(Address) Woodlawn

15 Filed July 26 1930 2 Ann. B. Puffer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 15 1929 to July 25 1930, that I last saw him alive on July 22, 1930,

and that death occurred on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

Contributory Secondary

(Duration) ys. mos. ds.

(Signed) Dr. William T. Ray M. D.  
7/26/30 1930 (Address) 928 Kenwood Dr

\*State the 1) Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ys. mos. ds. In the State ys. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Landon Park DATE OF BURIAL July 28 1930

20 UNDERTAKER Wm J. Tickner ADDRESS W & Ga

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Al. S. M. Freney  
1928 Penna Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

06475

## CERTIFICATE OF DEATH. (S)

1-PLACE OF DEATH Dundalk, Maryland.County  
CITY OF BALTIMORE: (No. 1741 Port Stuy Road ST. WARD)2-FULL NAME Baby Hilbinger(a) RESIDENCE No. 1741 Port Stuy Road ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,  
or Divorced, (write the word)MaleWhite.single.5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofnone.6 DATE OF BIRTH (month, day, and year) June 3, 1930

7 AGE

Years

Months

Days

If LESS than  
1 day, 0 hrs.  
or 0 min.5 months  
in utero.000

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of worknone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)none

(c) Name of employer

none9 BIRTHPLACE (city or town) Dundalk, Md.  
(State or country)10 NAME OF FATHER Harry Bert.11 BIRTHPLACE OF FATHER (city or town) Balto Md.  
(State or country) 4012 MAIDEN NAME OF MOTHER Helen Hilbinger13 BIRTHPLACE OF MOTHER (city or town) Balto Md.  
(State or country)

14

Informant  
(Address)R.D. Hilbinger  
1741 Port Stuy Rd

15

Filed

6/4/30 H. M. Leasure  
RegistrarREGISTERED NO. 41  
(If death occurred in  
a hospital or institu-  
tion, give its NAME  
instead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

June 3, 1930, to June 3, 1930,  
that I last saw h. dead June 3, 1930and that death occurred, on the date stated above, at 4.00 P. M.

The CAUSE OF DEATH\* was as follows:

E.S.T.Accident of Pregnancy (143)  
(a) aspiration;Premature Birth (161) 5th mo.

(duration) yrs. mos. ds.

CONTRIBUTORY Stillbirth  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James S. Marston, M. D.(Address) 214 Medical Arts Bldg\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Menns and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plater*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrephy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City White Marsh (No. \_\_\_\_\_)2 FULL NAME James M. Hill

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

March 4, 1896  
(Month) (Day) (Year)

7 AGE

94 yrs. 0 mos. 19 ds.  
IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Washington D. C.

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or Country)Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benjamin F. Cullum

(Address)

White Marsh Md.

15

Filed

3. 24. 1930 J. F. H. Gorman  
Registrar

02633

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 40

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 23, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192that I last saw him alive on 1230 P. M. 192and that death occurred on the date stated above, at 1230 P. M.

The CAUSE OF DEATH \* was as follows:

old age with  
arteriosclerosis  
and general debility

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. P. H. Gorman M. D.3. 24. 1930 (Address) Port Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Camp Chapel Cemetery March 25, 1930

20 UNDERTAKER

ADDRESS

Frederick Lassahnons Fullerton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

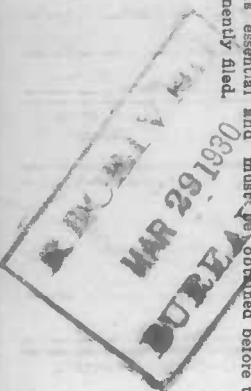
(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PRIESTS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

03987

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

39

Village or City

Bayville

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Lily Hill

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

4 18 1930  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day 2 hrs.

yrs. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore Md

10 NAME OF FATHER

Rud Hill

11 BIRTHPLACE OF FATHER

(State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Pearl McMillan

13 BIRTHPLACE OF MOTHER

(State or Country)

N. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rud Hill

(Address)

Parkton Md

15

Filed

April 19 1930

1930

Francis H. Blake  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4 19 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

4-18 1930 to 4-19 1930

that I last saw him alive on 4-18 1930

and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH \* was as follows:

Asphyxiation

Contributed (Duration) yrs. mos. ds.  
Primary Secondary(Signed) M. D.  
4-19 1930 (Address) Sparks Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bayville Cemetery

4-20 1930

20 UNDERTAKER

ADDRESS

Wm C. Brooks &amp; Sons

Sparks

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 6 1900

SUBRA



## HEALTH DEPARTMENT—CITY OF BALTIMORE

02634

## CERTIFICATE OF DEATH (90)

## 1—PLACE OF DEATH

REGISTERED NO. 44

CITY OR BALTIMORE: (No. Stemmer Run Rd STD WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 6a If married, widowed, or divorced

(WIFE of)

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

Feb. 16, 1930

John G. Canale Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar 17, 1930 to Mar 22, 1930

that I last saw him alive on Mar 23, 1930

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

## 18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

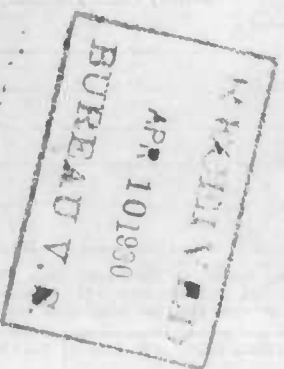
[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As thenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



N B--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto</u>		03988 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Batonville</u> (No. <u>201</u> )		Registration Dist. No. <u>30</u> Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary E Hill</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	6 DATE OF DEATH <u>April 21</u> , 19 <u>30</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>Feb 3</u> , 19 <u>05</u> (Month) (Day) (Year)		7 AGE <u>25</u> yrs. <u>2</u> mos. <u>17</u> ds. or min.?	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)		9 BIRTHPLACE (State or country) <u>Batonville Md</u>	
10 NAME OF FATHER <u>Thos H Squirrel</u>		11 BIRTHPLACE OF FATHER (State or country) <u>Carroll Co Md</u>	
12 MAIDEN NAME OF MOTHER <u>Rebecca J Davis</u>		13 BIRTHPLACE OF MOTHER (State or country) <u>Carroll Co Md</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Thos H Squirrel</u> (Address) <u>201 Winter Ave Balto Md</u>			
15 Filed <u>4/24</u> 19 <u>30</u> <u>3</u> Deputy Registrar		16 MEDICAL CERTIFICATE OF DEATH I HEREBY CERTIFY, That I attended the deceased from <u>July 1</u> , 19 <u>26</u> to <u>April 21</u> , 19 <u>30</u> , that I last saw him alive on <u>April 20</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>3:40 P</u> M. The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>4</u> yrs. <u>2</u> mos. <u>17</u> ds. Contributory Secondary (Signed) <u>Thos H Squirrel</u> M. D. <u>4-23</u> 19 <u>30</u> (Address) <u>703 W 70th St</u> *State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.	
16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death. yrs. <u>4</u> mos. <u>17</u> ds. In the State. yrs. <u>4</u> mos. <u>17</u> ds. Where was disease contracted, if not at place of death? Former or usual residence.		17 PLACE OF BURIAL OR REMOVAL <u>Johnsville Cem</u> 18 DATE OF BURIAL <u>April 24</u> , 19 <u>30</u> 19 UNDERTAKER <u>Samuel H Newsley</u> 20 ADDRESS <u>118 E 1st St</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only, are not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association?).

If this certificate is filed over thoroughly and accurately as directed in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1903  
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Baltimore*

Village or City

*Harlem*

(No.)

*Indie Ave.*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Miss Born Helary*Registration Dist. No. *42*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*S.*

6 DATE OF BIRTH

*Sept 4**1920*

(Month)

(Day)

(Year)

7 AGE

*0 yrs. 0 mos. 0 ds.*

IF LESS than

1 day 0 hrs.

or 0 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Baltimore Md.*

10 NAME OF FATHER

*Charles Helary Jr.*

11 BIRTHPLACE OF FATHER

(State or country)

*Md.*

12 MAIDEN NAME OF MOTHER

*Virginia Powell*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

*Sept 18 1920**Dr. McKee*

Registered

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Miss Born**1920*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*1920*

to

*1920*that I last saw him alive on *1920*and that death occurred on the date stated above, at *m.*

The CAUSE OF DEATH \* was as follows:

*Miss Born - Cause unknown*  
*Death states fall 29 3 days*  
*known*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

*Frederic V. Beuter*

M. D.

*Sept 5 1920*

(Address)

*Harlem, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*6 Reuses*

DATE OF BURIAL

*Sept 4 1920*

20 UNDERTAKER

*None.*

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 3 1900  
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City Long Beach (No. \_\_\_\_\_)

2 FULL NAME Ida Hirschmann

150 01387  
(101-a)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME, its street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug. 20th, 1859  
(Month) (Day) (Year)

7 AGE 70 yrs. 5 mos. 16 ds. or 1 day 0 hrs. 0 min. If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Herman Miller

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Ladie Lidsch

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emil Hirschmann

(Address) Long Beach

15 Filed 2/8/1930 John S. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 6th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192\_\_\_\_, to \_\_\_\_\_, 192\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 192\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Jacob Dahman Coroner M. D.  
192\_\_\_\_ (Address) Stemmers Run

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lorraine Cemetery DATE OF BURIAL 2/8/1930

20 UNDERTAKER John S. Connolly ADDRESS Cossey

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 6 1890  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			0184		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			74-a		Registration Dist. No. <u>32</u>	
Village or City <u>Pikesville</u> (No. _____)			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John A. Hitchcock</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)				
6 DATE OF BIRTH <u>June 19</u> , 18 <u>67</u> (Month) (Day) (Year)						
7 AGE <u>62</u> yrs. <u>7</u> mos. <u>28</u> ds. or _____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Insurance Broker</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Baltimore</u>						
9 BIRTHPLACE (State or country) <u>MD</u>						
10 NAME OF FATHER <u>John A. Hitchcock</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>						
12 MAIDEN NAME OF MOTHER <u>Sarah L. Anderson</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>MD</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John A. Hitchcock</u> (Address) <u>Pikesville MD</u>						
15 Filed <u>1/18/1930</u> <u>H. E. Nichols</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Jan 17</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 15</u> , 19 <u>30</u> , to <u>Jan 17</u> , 19 <u>30</u> , that I last saw him alive on <u>Jan 17</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9 A</u> m. The CAUSE OF DEATH * was as follows: <u>Edema of lungs</u> (Duration) _____ yrs. _____ mos. <u>4 hrs.</u> ds.						
Contributory Secondary <u>Cerebral Hemorrhage</u> (Duration) _____ yrs. _____ mos. <u>2</u> ds.						
(Signed) <u>G. E. Nichols</u> M. D. <u>1-17</u> , 19 <u>30</u> (Address) <u>Pikesville MD</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.						
Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Green Ridge</u> DATE OF BURIAL <u>Jan 20</u> , 19 <u>30</u>						
20 UNDERTAKER <u>John D. Mitchell</u> ADDRESS <u>1900 Eutan Place</u>						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 8 1900

RECEIVED



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

14686

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Garrison (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Otis Eugene Hitchcock

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 27, 1867  
(Month) (Day) (Year)

7 AGE 63 yrs. 8 mos. 27 ds. or 7 min. 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min. 2

8 OCCUPATION  
(a) Trade, profession or particular kind of work Motorman  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co. Md

10 NAME OF FATHER Edward Hitchcock

11 BIRTHPLACE OF FATHER (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Sus Constantine

13 BIRTHPLACE OF MOTHER (State or Country) Balto Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Hitchcock  
(Address) Garrison

15 Filed Dec 1 1930 E E Nichols  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 1st (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 29 to Dec 1st, 1930, that I last saw him alive on Dec 1st, 1930,

and that death occurred on the date stated above, at 4:45 m. The CAUSE OF DEATH \* was as follows:

Diabetic gangrene of left leg  
Chorea (Duration) 1 yrs. XX mos. XX ds.

Contributory Secondary Chorea (Duration) 1 yrs. XX mos. XX ds.

(Signed) J. Frank Miller M. D.  
1701 1/2 1930 (Address) Reston

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery DATE OF BURIAL Dec 3rd, 1930

20 UNDERTAKER Wm Cook ADDRESS Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

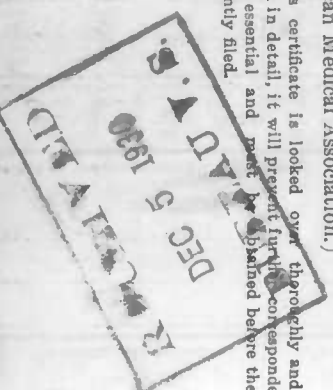
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations, a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archibed, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be explained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Dobins (No. \_\_\_\_\_)

2 FULL NAME Baby Hibelcoch

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 32

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 18th 1920  
(Month) (Day) (Year)

7 AGE Still Born 6 mos If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Child  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Balto Co. Md

10 NAME OF FATHER Carroll E. Hibelcoch

11 BIRTHPLACE OF FATHER (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Esther Hibelcoch

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carroll E. Hibelcoch

(Address) Dobins

15 Filed Sept 19- 1920 E. E. Nicholas  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 18th 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 18th 1920 to Sept 18th 1920, that I last saw him alive on Sept 18th 1920, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still Born

(Duration) X yrs. X mos. X ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. F. Daugherty M. D.  
9/18/20 (Address) Baltimore Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pleasant Hill Cem - DATE OF BURIAL Sept 19- 1920

20 UNDERTAKER Howe ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonæum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

07763

(129)

Registration Dist. No. 37

## 2 FULL NAME

St. Ward)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, ☒  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day....hrs.  
.....yrs.....mos.....ds.or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1930

B. B. Bennett

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

chronic interstitial nephritis  
Rheumatism

(Duration) 1 yrs. 6 mos. ds.

Contributory  
Secondary

(Duration) 1 yrs. 6 mos. ds.

(Signed)

B. B. Bennett M.D.

July 28, 1930 (Address) Corbyville, Mo.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs.....mos.....da.

In the State.... yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Alma Home County

July 30, 1930

20 UNDERTAKER

ADDRESS

W. C. Brooks

Spartan, Mo.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection, if it, respected to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Reveler's wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be used over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 6 1918  
BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Overlea(No. 10 E. Overlea Ave2 FULL NAME Sarah C. HofmeisterSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)married

6 DATE OF BIRTH

July 11, 1874  
(Month) (Day) (Year)

7 AGE

56 yrs. 3 mos. 18 ds. or LESS than  
1 day.....hrs. or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore Md.

10 NAME OF FATHER

Thos. Garrison

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary D. Leides

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C. Hofmeister

(Address)

10 E. Overlea Ave

15

Filed 11/11930G. A. Fintz, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Oct 14, 1930 to Oct 29, 1930that I last saw him alive on Oct 29, 1930and that death occurred on the date stated above, at 1145 P. m.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia(Duration) yrs. 3 mos. 3 ds.Contributory  
SecondaryAcute Psychosis(Duration) yrs. 14 mos. 14 ds.

(Signed)

Joseph P. Kennedy

M. D.

Oct 31, 1930(Address) 2200 E. W. Woodward

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parkwood CemeteryNov. 2, 1930

20 UNDERTAKER

ADDRESS

Frederick L. Lashbrook7401 Belair Rd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebraspinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical means was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—capitol acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 4 1900

BUREAU

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

10148

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St. \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Joseph. Wulcher

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m.

4 COLOR OR RACE

w5 SINGLE, MARRIED, married  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

march 19, 1885  
(Month) (Day) (Year)

7 AGE

45 yrs. 5 mos. 15 ds. or \_\_\_\_\_ min.?If LESS than  
1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry business, or establishment in which employed or (employer).

9 BIRTHPLACE  
(State or country)Baltimore

10 NAME OF FATHER

Peter Wulcher11 BIRTHPLACE OF FATHER  
(State or country)Bohemia, Europe

12 MAIDEN NAME OF MOTHER

Barbara Pokorny13 BIRTHPLACE OF MOTHER  
(State or Country)Bohemia, Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Hospital Records--Personal History  
(Informant)Eudowood Sanatorium, Towson, Md.

15

Filed Sept 7 1930 Wm. P. Butler Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. October (Month) 4 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

aug. 30 1926 to Sept. 4, 1930,  
that I last saw him alive on Sept 3, 1930,and that death occurred on the date stated above, at 6.57 a.m.  
The CAUSE OF DEATH \* was as follows:pulm. Tb.(Duration) 6 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. G. Bridges M. D.1930 (Address) Towson, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the life State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL

Holy Redeemer

DATE OF BURIAL

Sept 8th 1930

20 UNDERTAKER

Frank Jackson 1906 Chilhard

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

atue

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

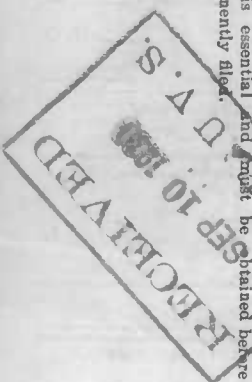
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. Four VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is *checked* over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

Village or City Catonsville (No. Rolling Rd. near Edmondson Ave. St.; Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Franklin Holland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH May 31, 1937  
(Month) (Day) (Year)

7 AGE 73 yrs. 4 mos. 25 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Manufacturer  
(b) General nature of industry business, or establishment in which employed (or employer) Self

9 BIRTHPLACE (State or country) Sorrell, Canada

10 NAME OF FATHER Joseph Holland

11 BIRTHPLACE OF FATHER (State or country) Canton, Maine

12 MAIDEN NAME OF MOTHER Margaret Ann Mountain

13 BIRTHPLACE OF MOTHER (State or country) Sorrell, Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna E. Holland  
Rolling Rd. near Edmondson Ave.  
(Address) Catonsville, Md.

15 Filed 10/27/30 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 25, 1930, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 11<sup>th</sup>, 1930, to Oct 25<sup>th</sup>, 1930

that I last saw him alive on Oct 24<sup>th</sup>, 1930

and that death occurred on the date stated above, at 4A a.m.

The CAUSE OF DEATH \* was as follows:

Acute Pneumonia  
(Duration) 15 ds.

Contributory Cerebral embolism  
Secondary Heart failure  
(Duration) 15 ds.  
(Signed) Shas Kuesle M. D.  
Frederick Rd.  
Catonsville, Md.

\* Since the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 15 yrs. 4 mos. 25 ds. Is the State, 15 yrs. 4 mos. 25 ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL Oct. 28, 1930

20 UNDERTAKER Wesley Cook ADDRESS 1003 West Baltimore St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930

BUREAU V

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto</u>		07764 (182)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Johnny Cake Rd Catonsville Md</u>		Registration Dist. No. <u>30</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>James F. Holland</u>		<u>Res 2703 Reggan Balto Md</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>M</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>5-18-1903</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>7-13-1923</u> (Month) (Day) (Year)			
7 AGE <u>27 yrs. 1 mos. 25 ds.</u> If LESS than 1 day hrs. or min.?		17 I HEREBY CERTIFY, That I attended the deceased from <u>1923</u> to <u>1923</u> , that I last saw him alive on <u>7-13-1923</u> , and that death occurred on the date stated above, at <u>1923</u> . The CAUSE OF DEATH * was as follows: <u>Accidental Drowning</u>			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>Chauf.</u>		(Duration) yrs. mos. ds.			
9 BIRTHPLACE (State or country) <u>Md</u>		Contributory Secondary (Duration) yrs. mos. ds.			
10 NAME OF FATHER <u>Winford Holland</u>		(Signed) <u>H. C. Anderson</u> M. D.			
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>		192 (Address) <u>Corner</u>			
12 MAIDEN NAME OF MOTHER <u>Helen McCormack</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Annie E. Holland</u> (Address) <u>2703 Reggan</u>		Where was disease contracted, if not at place of death? Former or usual residence			
15 Filed <u>7/14/1923</u> <u>H. C. Anderson</u> Registrar		19 PLACE OF BURIAL OR REMOVAL <u>Woodlawn Ave</u>		DATE OF BURIAL <u>7/16-19</u>	
		20 UNDERTAKER <u>Henry Lutz</u>		ADDRESS <u>1205X Road</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of ("Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonocum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death removed by ~~XXXXXX~~ on ~~XXXXXX~~ Nomenclature of the ~~XXXXXX~~ Medical Association.)

If this certificate is ~~XXXXXX~~ over ~~XXXXXX~~ thoroughly and all questions answered ~~XXXXXX~~ will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County Baltimore

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 31Village or City Woodlawn (No. Windsor Mill Road St. \_\_\_\_\_ Ward \_\_\_\_\_)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edith Virginia Hollenshade

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

August 8, 1884  
(Month) (Day) (Year)

7 AGE

45 yrs. 9 mos. 13 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

Housework9 BIRTHPLACE  
(State or country)Maryland10 NAME OF  
FATHERJoseph Perkins Brooks11 BIRTHPLACE  
OF FATHER  
(State or country)Maryland12 MAIDEN NAME  
OF MOTHERAgnes Lee Webb13 BIRTHPLACE  
OF MOTHER  
(State or Country)Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Lawrence Hollenshade

(Address)

Woodlawn Md

15

Filed

5/22/1923 Dr. Ruffer

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 22, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended the deceased from  
December 30, 1923 to May 22, 1930that I last saw her alive on May 21, 1930and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis withMitral Valve insufficiency(Duration) 25 yrs. 0 mos. 0 ds.Contributory Dental Caries - duration 7 yearsSecondary Chronic Nephritis uncertain yrs. 0 mos. 0 ds.(Signed) Joshua H. Arnason M. D.May 22, 1930 (Address) Woodlawn, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

WoodlawnMay 26, 1930

20 UNDERTAKER

ADDRESS

Chenoweth & Son3615 Chestnutave



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worker on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonoeum*, etc., *Coronoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; (*chronic valvular heart disease*; *Chronic interstital nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

*Indefinite*

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Calgate, Md. (No. 48th St. German Hill Road)

2 FULL NAME Mary Holoman

10147 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH 4 May 6, 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. 14 ds. or 14 min. If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Martin Holoman

11 BIRTHPLACE OF FATHER (State or country) Bahemia

12 MAIDEN NAME OF MOTHER Mary Walberg

13 BIRTHPLACE OF MOTHER (State or Country) Bahemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Holoman

(Address) 48th German Hill Road

15 Filed Sept 20 1930 John G. Connelly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 6, 1930 to Sept 20, 1930, that I last saw her alive on Sept 19, 1930

and that death occurred on the date stated above, at — m. The CAUSE OF DEATH \* was as follows:

Dysentery Toxicary.

(Duration) 20 yrs. — mos. — ds.

Contributory Acute Myocarditis

(Duration) 3 yrs. — mos. — ds.

(Signed) Harace B. Sittow M. D.

192 (Address) 315 S. Highland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Sacred Heart of Mary

DATE OF BURIAL Sept 22, 1930

20 UNDERTAKER George A. Weber

ADDRESS 205 S. Ann St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			08969 74-a	
Village or City <u>Spring Grove Hospital -</u>			Registration Dist. No. <u>30</u>	
(No. <u>Batonsville, Md.</u> )			St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary Holmes</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>November 17, 1847</u> (Month) (Day) (Year)				
7 AGE <u>82 yrs. 8 mos. 20 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
10 NAME OF FATHER <u>Samuel Holmes</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
12 MAIDEN NAME OF MOTHER <u>Anna Parrish</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Emma Holmes</u> (Address) <u>Baltimore Md.</u>				
15 Filed <u>77</u> 192 <u>30</u> <u>H. J. Judson</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>August 6, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 8, 1927</u> to <u>Aug 6, 1930</u> that I last saw her alive on <u>Aug 6, 1930</u> and that death occurred on the date stated above, at <u>12 P. m.</u> The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u> (Duration) <u>2 days</u> Contributory <u>Atherosclerosis</u> Secondary (Duration) <u>10 yrs.</u> (Signed) <u>Arthur L. Wright</u> M. D. <u>Aug. 7, 1930</u> (Address) <u>Batonsville</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>2 yrs. 3 mos. 29 ds.</u> In the State <u>life</u> Where was disease contracted, if not at place of death? <u>at home</u> Former or usual residence <u>5312 Belleville Ave Baltimore Md.</u>				
19 PLACE OF BURIAL OR REMOVAL <u>St Mary's Hampden</u> DATE OF BURIAL <u>Aug 9, 1930</u>				
20 UNDERTAKER <u>Wm Cook</u> ADDRESS <u>1217 N Paul St</u>				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Coronoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# <sup>1</sup> PLACE OF DEATH

County

Village or City Middle River (No. 1)

2FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44

St.:.....Ward) (if death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

### 3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED.  
~~OR DIVORCED~~  
(Write the word)

6 DATE OF BIRTH

7 AGE

6 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF  
FATHER

11 BIRTHPLACE  
OF FATHER  
(State or country)

12 MAIDEN NAME  
OF MOTHER

**13 BIRTHPLACE  
OF MOTHER**  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

## Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Baito., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw h er alive on July 17, 1923

and that death occurred on the date stated above, at 1330 m.

The CAUSE OF DEATH \* was as foliows:

### Contributory Secondary

(Signed) \_\_\_\_\_ M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.      In the State.....yrs.....mos.....ds.

Where was disease contracted,  
if not at place of death?.....

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

16 W. Saratoga St., Baito., Requesting V. S. No. 1.

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

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1001 62 MR  
REGISTERED

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICAL STATE should be stated EXACTLY, CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH.

County

Baltimore

08970

(91-2)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

30

Registration Dist. No.

Village or City

Catonsville

(No.)

Spring Grove State Hospital

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Harace B. Hood

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

widowed

6 DATE OF BIRTH

August 8

(Month)

8

(Day)

1930

(Year)

7 AGE

79

yrs.

mos.

ds.

or

min. ?

If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Howard Co.

10 NAME OF FATHER

Raim Hood

11 BIRTHPLACE OF FATHER

(State or country)

Howard Co.

12 MAIDEN NAME OF MOTHER

Margaret Anderson

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

History of Patient from death certificate statement.

(Address)

15

Filed

192

W. H. Anderson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 8

(Month)

(Day)

1930

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

January 14

1929

to August 8

1930

that I last saw him alive on August 8

1930

and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH was as follows:

Arteriosclerosis, general(Duration) 10 yrs. .... mos. .... da.Contributory  
Secondary

(Duration) .... yrs. .... mos. .... da.

(Signed) Frank E. Brown M.D.Aug. 9, 1930 (Address) Catonsville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

1 yr. 11 mos. 24 da.

In the

Lifetime State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Unknown

Former or usual residence

Dorsey, Anne Arnold Co.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spring Grove State Hospital 7.11.1930

20 UNDERTAKER

ADDRESS

Spring Grove State Hospital Catonsville, Md.

If more blanks are needed, address State Registrar, 16 W. Stratoga St., Balto., Requesting V. S. NO. 1

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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Sailorman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-keeper*, or *At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Tronp"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retriever wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			10836		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Woodlawn</u> (No. <u>Windsor Mill Road</u> St.: _____ Ward) _____			Registration Dist. No. <u>61</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Frank Hooker</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widower</u> (Write the word)				
6 DATE OF BIRTH <u>May 9</u> 19 <u>28</u> (Month) (Day) (Year)						
7 AGE <u>72</u> yrs. <u>4</u> mos. <u>16</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
10 NAME OF FATHER <u>Jacob B. Hooker</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						
12 MAIDEN NAME OF MOTHER <u>Catherine Joyce</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ethel Dittman</u> (Address) <u>Woodlawn, Md.</u>						
15 Filed <u>Sept. 26</u> 19 <u>30</u> <u>20 m. n. B. Buffen</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Sept. 24</u> 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 1</u> 19 <u>30</u> to <u>Sept. 24</u> 19 <u>30</u> , that I last saw him alive on <u>Sept. 24</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>9:46 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Carcinoma of Stomach</u> (Duration) _____ yrs. <u>6</u> mos. _____ ds.						
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.						
(Signed) <u>Joshua H. Amason</u> M. D. <u>Sept. 24</u> 19 <u>30</u> (Address) <u>Woodlawn, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Woodlawn Bur.</u> DATE OF BURIAL <u>Sept. 27</u> 19 <u>30</u>						
20 UNDERTAKER <u>Joseph B. Cook</u> ADDRESS <u>1003 N. Calver</u>						



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal meningitis*); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tumia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

1 PLACE OF DEATH			01388		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Balto</u>					Registration Dist. No. <u>42</u>	
Village or City <u>Ashutus</u> (No. <u>Buck arr</u> )			St. <u></u> Ward <u></u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John W. Hoor</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>				
6 DATE OF BIRTH <u>Dec. 8, 1861</u> (Month) (Day) (Year)						
7 AGE <u>68</u> yrs. <u>2</u> mos. <u>8</u> ds. or <u></u> LESS than 1 day <u></u> hrs. <u></u> min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Meat</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Bohary Co</u>						
9 BIRTHPLACE (State or country) <u>Balto Md</u>						
PARENTS	10 NAME OF FATHER <u>John Hoor</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>					
	12 MAIDEN NAME OF MOTHER <u>Louise Schultz</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Hoor</u> (Address) <u>1916 Brentwood</u>						
15 Filed <u>July 17, 1930</u> <u>St. M. Kieffer</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>July 16, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 16, 1930</u> to <u>July 16, 1930</u>						
that I last saw him alive on <u>July 16, 1930</u>						
and that death occurred on the date stated above, at <u>5 a</u> m.						
The CAUSE OF DEATH * was as follows: <u>Mitral Regurgitation</u> (Duration) <u>1</u> yrs. <u></u> mos. <u></u> ds. Contributory <u>Myocardial degeneration</u> Secondary <u>shoulder</u> (Duration) <u></u> yrs. <u></u> mos. <u></u> ds. (Signed) <u>St. M. Kieffer</u> M. D. <u>July 17, 1930</u> (Address) <u>42 Buck arr</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u></u> yrs. <u></u> mos. <u></u> ds. In the State <u></u> yrs. <u></u> mos. <u></u> ds. Where was disease contracted, if not at place of death? <u></u> Former or usual residence <u></u>						
19 PLACE OF BURIAL OR REMOVAL <u>London Park Cem.</u>						DATE OF BURIAL <u>July 19, 1930</u>
20 UNDERTAKER <u>George L. Schmitz</u>						ADDRESS <u>Frederick</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH  
County Balto.

Village or City Sue Grove (No. St. Elv's #63)

2 FULL NAME John Hoover

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. 44 Ward 44 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH about 1 865 (Month) (Day) (Year)

7 AGE About 65 yrs. mos. ds. or min. If LESS than 1 day... hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Shorekeeper (b) General nature of industry business, or establishment in which employed or (employer) Joseph Eslinger

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER 1)

11 BIRTHPLACE OF FATHER (State or country) 1)

12 MAIDEN NAME OF MOTHER 1)

13 BIRTHPLACE OF MOTHER (State or Country) 1)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Eslinger  
(Address) 637 G. 37th St.

15 Filed June 21 1930 John G. Connolly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Apoplexy

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) Jacob Hallman Coroner M. D.  
192 (Address) Stomachs Run

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wachman's Cemetery DATE OF BURIAL June 21, 1930

20 UNDERTAKER John G. Connolly ADDRESS Essex

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH  
County Baltimore

Village or City EUDWOOD SANATORIUM, TOWSON, MD.

2 FULL NAME John Philip Hoover

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE w 5 SINGLE, MARRIED, X WIDOWED, OR DIVORCED (Write the word)  
6 DATE OF BIRTH Sept 19, 1894  
(Month) (Day) (Year)  
7 AGE 35 yrs. 9 mos. 11 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work High Miner  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Hazeldell, Pa

10 NAME OF FATHER Andrew Hoover

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Meyer

13 BIRTHPLACE OF MOTHER (State or Country) Pittsburg Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records--Personal History  
(Informant)

Eudwood Sanatorium, Towson, Md.  
(Address)

15 Filed July 31, 1920 H. P. Buck  
Registrar

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 908

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 30, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the decedent from July 18, 1920 to July 30, 1920, that I last saw him alive on July 30, 1920, and that death occurred on the date stated above, at 6 P. m.  
The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) W. G. Bridges M. D.  
1920. (Address) Towson, Maryland.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pittsburg Pa DATE OF BURIAL July 31, 1920

20 UNDERTAKER Wm. Coof ADDRESS Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia (secondary)*, *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

03980 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 39

Village or City Phoenix Md (No. 129)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lizzie Jane Hoover

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

8 DATE OF BIRTH Jan 9, 1870  
(Month) (Day) (Year)

7 AGE 60 yrs. 2 mos. 29 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) at her home

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Robert C. Fisher

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER May Catherine Bony

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. J. Hoover

(Address) Phoenix Md

15 Filed 4/8 1930 Francis H. Blake Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 28, 1928 to April 4, 1930, that I last saw her alive on April 4, 1930, and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH \* was as follows:  
Nephritis Cystitis  
Chronic Bronchitis

(Duration) 1 yrs. 4 mos. 9 ds.  
Contributory Secondary Pulmonary Embolism

(Signed) Bruf. S. Brown M. D.  
April 8, 1930 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Poplar M. S. Cemetery DATE OF BURIAL April 9, 1930

20 UNDERTAKER Wm. C. Brooks & Son ADDRESS Sparks, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 6 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Baltimore*

13560

247

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

44

Village or City

*Essex*

(No.)

*River Side Drive*

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Laurence Hopstetter*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Married*

6 DATE OF BIRTH

*Oct.**25**1870*

(Month)

(Day)

(Year)

7 AGE

*55*

yrs.

mos.

*26*

ds.

If LESS than

1 day

hrs.

or

min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Foundry Foreman*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Balto. Co.*

10 NAME OF FATHER

*Frank Hopstetter*

11 BIRTHPLACE

OF FATHER

(State or country)

*Balto. Co.*

12 MAIDEN NAME OF MOTHER

*Amelia Sepper*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Marionette Hopstetter*

(Address)

*River Side Drive*

15

Filed

*Nov. 22**1930**John B. Connolly*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*November 20**1930*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Nov. 14**1930*to *Nov. 20**1930*that I last saw him alive on *Nov. 19**1930*and that death occurred on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH \* was as follows:

*Apical Polar Pneumonia*

(Duration)

yrs.

mos.

*6*

ds.

20 Contributory

Secondary

*Edema of the lungs,**myocarditis*

(Duration)

yrs.

mos.

*3*

ds.

(Signed)

*Jos. A. Rosenblatt*

M. D.

*11/20**1930*

(Address)

*3018 O'Donnell St.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cemetery**Nov 23, 1930*

20 UNDERTAKER

ADDRESS

*Mrs. C. Miller & Son 2334 Jefferson*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

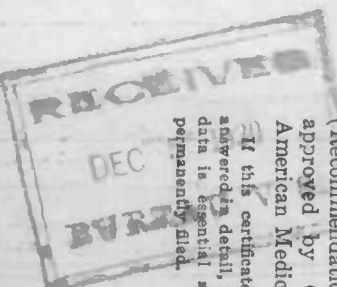
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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1 PLACE OF DEATH		02635		STATE OF MARYLAND	
County <u>Baltimore</u>		(742)		CERTIFICATE OF DEATH	
Village or City <u>Catonsville</u> (No. <u>only Home</u> )		St. _____ Ward _____		Registration Dist. No. <u>30</u>	
2 FULL NAME <u>John Horn</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>			
6 DATE OF BIRTH <u>May 12 1858</u> (Month) (Day) (Year)					
7 AGE <u>72</u> yrs. <u>9</u> mos. <u>5</u> ds. or <u>25</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Retired</u>					
9 BIRTHPLACE (State or country) <u>Ind.</u>					
10 NAME OF FATHER <u>Jacob Horn</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>					
12 MAIDEN NAME OF MOTHER <u>Unk.</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unk.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Kathleen Horn</u>					
(Address) <u>Green Ave.</u>					
15 Filed <u>3/10</u> 19 <u>30</u> <u>St. Michael's</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 7</u> 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 1929</u> to <u>March 7</u> 19 <u>30</u> , that I last saw him alive on <u>March 6</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>11 A.M.</u> The CAUSE OF DEATH * was as follows:					
<u>Cerebral Hemorrhage</u>					
(Duration) <u>1</u> yrs. <u>6</u> mos. <u>ds.</u>					
Contributory Secondary <u>arterio sclerosis</u>					
(Duration) <u>1</u> yrs. <u>6</u> mos. <u>ds.</u>					
(Signed) <u>Marshall B. West</u> M. D. <u>March 7</u> 19 <u>30</u> (Address) <u>Catonsville Ind.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death <u>3</u> yrs. <u>3</u> mos. <u>ds.</u> In the State <u>72</u> yrs. <u>mos.</u> <u>ds.</u>					
Where was disease contracted, if not at place of death? <u>Ind.</u>					
Former or usual residence <u>Ind.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>St. Michael's</u> DATE OF BURIAL <u>3/11</u> 19 <u>30</u>					
20 UNDERTAKER <u>Fredk. Lassman</u> ADDRESS <u>Fullerton</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

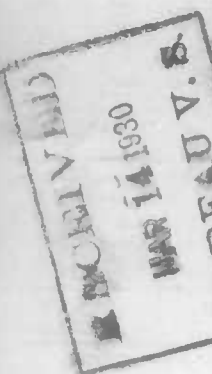
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Rosedale (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Horst

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH Mar 14, 1930  
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ mo. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

8 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Horst

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alma Engelke

13 BIRTHPLACE OF MOTHER (State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alma Horst(Address) Rosedale Md.

15 Filed Mar 14, 1930 John G. Connolly  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1930 to Mar 14, 1930

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Still Born  
(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Contributory Stillborn  
Secondary (Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

(Signed) George C. [illegible] M. D.  
Mar 14, 1930 (Address) 5631 [illegible]

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds. In the State, \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.  
Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore's Cem. DATE OF BURIAL 3/14/1930

20 UNDERTAKER John G. Connolly ADDRESS Essex

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 7 1910

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

03930

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43Village or City Fullerton (No. Smith Ave. & Joppa Rd. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Amelia Horstmeier

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

April 18, 1845  
(Month) (Day) (Year)

7 AGE

84 yrs. 11 mos. 16 ds. or IF LESS than  
1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

None

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Frank Carl Rittler

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Herman Bark  
Fullerton Md.

15

Filed

4/61930G. A. Fritz

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 4, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 30, 1929, to April 4, 1930, that I last saw he alive on April 3rd, 1930.and that death occurred on the date stated above, at 1250 a.m.  
The CAUSE OF DEATH \* was as follows:arterio-scleroticContributory  
Secondary(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) Edwin J. Weaver M. D.  
4/5/30 1930 (Address) Orester Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trinity Cemetery April 7, 1930

20 UNDERTAKER

ADDRESS

Frederick L. Lashburne Fullerton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 2 1930  
BUREAU

MARGIN RESERVED FOR BINDING  
WRITE PRINTED, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Baltimore

Village or City

North Haledrop

2 FULL NAME

Mabel E. Hancock

07707  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

June 10 1869  
(Month) (Day) (Year)

7 AGE

41 yrs. 1 mos. 1 ds. or mint?  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Elihu Hale

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Anne Rorstein

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clearance E. Hancock

(Address)

504 S. Second St.

15 Filed

July 12 1930

Geo. McKieff

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 11 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 1922, to July 11 1930

that I last saw him alive on July 11 1930,

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

Angine Heart disease

(Duration) 1 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Edwarda Morgan M. D.

July 11 1930 (Address) 1325 W. Fayette

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Friendship Anne July 14 1930

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Son Chestnut St

Mr. J. A. Hall

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AUG 4 1930  
BUREAU V. S.



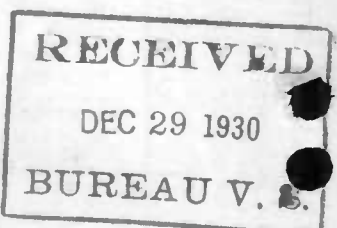


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1 PLACE OF DEATH County <u>Baltimore</u>			01389 (45)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Halethorpe</u>			St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Emma Joe House</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>June 29</u> , 18 <u>61</u> (Month) (Day) (Year)						
7 AGE <u>68</u> yrs. <u>7</u> mos. <u>28</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Domestic</u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>Indiana</u>						
10 NAME OF FATHER <u>Thomas Jefferson House</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Lynchburg, Va.</u>						
12 MAIDEN NAME OF MOTHER <u>Hannett Amelia Hoffman</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Baltimore City, Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Allie E. Dickson</u> (Address) <u>1st Ave. West Halethorpe</u>						
15 Filed <u>Feb 28</u> 19 <u>30</u> <u>John H. Porter</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Feb 26</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 1</u> , 19 <u>30</u> to <u>Feb 26</u> , 19 <u>30</u> . That I last saw her alive on <u>Feb 26</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>10 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Lympho. Sarcoma of Liver</u> <u>and of spleen, &amp; General Metastasis</u> (Duration) _____ yrs. <u>4</u> mos. _____ ds. Contributory <u>Myocardial Chnaff.</u> Secondary _____ (Duration) _____ yrs. <u>2</u> mos. _____ ds. (Signed) <u>B. B. Brumby</u> , M. D. <u>Feb 26</u> , 19 <u>30</u> (Address) <u>Elkridge Md.</u> *State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>St. Mary's Cem</u>					DATE OF BURIAL <u>March 1st</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Joseph Cook</u>					ADDRESS <u>1003 R. D. 1</u>	

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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MAR 4 1930

BUREAU

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

08971

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Riderwood (No. Joppa Road St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Benjamin Chew Howard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH November 8, 1868  
(Month) 8 (Day) 1868 (Year)

7 AGE 61 yrs. 9 mos. 25 ds. IF LESS than 1 day \_\_\_\_ hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Sec. & Treas.  
(b) General nature of industry, business, or establishment in which employed or (employer) of Balto. Trust Co.

9 BIRTHPLACE (State or country) Baltimore Md

10 NAME OF FATHER Jr. G. Howard

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cennie Layle

13 BIRTHPLACE OF MOTHER (State or country) India

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Elizabeth White Howard(Address) Riderwood Md15 Filed Aug 4 1930 V. S. No. 1 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 3<sup>rd</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 1<sup>st</sup> 1929 to Aug 3<sup>rd</sup> 1930.

that I last saw him alive on Aug 3<sup>rd</sup> 1930.

and that death occurred on the date stated above, at 7 P.M. D-5-1.

The CAUSE OF DEATH \* was as follows: Chronic Nephritis

Contributory Coronary (Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Chas W. Van Wyk M. D.  
8-4-30 (Address) 1515 Park Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Greenmount Cem DATE OF BURIAL Aug 6<sup>th</sup> 1930

20 UNDERTAKER Wm. J. Jenkins & Co ADDRESS 16-17 Calver St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

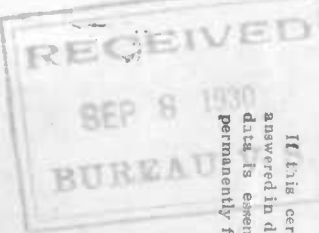
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Workmen at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesenteric Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.





N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Baltimore

13561

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 34

Village or City

Reisterstown R.D.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Thomas E. Howard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Nov. 12, 1930  
(Month) (Day) (Year)

7 AGE

Mis Carriage

If LESS than  
1 day... hrs.  
... yrs. ... mos. ... ds. or ... min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work.(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Reisterstown R.D. Md.

10 NAME OF  
FATHER

Lorenzo T. Howard

11 BIRTHPLACE  
OF FATHER

(State or country)

Balt. Co. Md.

12 MAIDEN NAME  
OF MOTHER

Barthel Madden

13 BIRTHPLACE  
OF MOTHER

(State or country)

Balt. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lorenzo T. Howard

(Address)

Reisterstown R.D. Md.

15

Filed

Nov. 12 1930

R.E. Trotter M.D.  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 12, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov. 12, 1930 to Nov. 12, 1930,  
that I last saw him alive on Nov. 12, 1930,  
and that death occurred on the date stated above, at 3 A.

The CAUSE OF DEATH \* was as follows: not known

Miscarriage (4th Month)

(Duration) ... yrs. ... mos. ... ds.

Contributory  
Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed)

John H. Drach

M.D.

Nov. 12, 1930

(Address)

Cockeysville Md.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death ... yrs. ... mos. ... ds.In the  
State ... yrs. ... mos. ... ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At Home

Nov. 12, 1930

20 UNDERTAKER

Lorenzo T. Howard

Father of child

ADDRESS

Reisterstown R.D. Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

DEC 1 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A. The data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

14688

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Beggs (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary A. Howell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH October 22, 1877  
(Month) (Day) (Year)

7 AGE 53 yrs. 1 mos. 21 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) ✓

10 NAME OF FATHER Alonzo Morris  
11 BIRTHPLACE OF FATHER New Jersey  
(State or country)  
12 MAIDEN NAME OF MOTHER Alice Shipley  
13 BIRTHPLACE OF MOTHER Balto. Md.  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. A. Brown(Address) Beggs, Md.

15 Filed Dec. 15, 1920 John S. Connelly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 13, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 8, 1920 to Dec 13, 1920, that I last saw her alive on Dec 11, 1920, and that death occurred on the date stated above, at 9:27 a.m.

The CAUSE OF DEATH \* was as follows:

Tuberculosis (T.B.)  
Pulmonary

(Duration) 7 yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Harry Hall M. D.  
Dec 13, 1920 Address Middle River

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cherry CemeteryDec 17, 1920

20 UNDERTAKER

ADDRESS

Hughes & Son 414 N. Broadway

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 5 1930  
BUREAU V. S.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH

County Baltimore

05276

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City Batonville (No. 625 Aldershot Road St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Loretta A. Hunt

PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX female <sup>4</sup> COLOR OR RACE white <sup>5</sup> SINGLE, MARRIED, WIDOWED OR DIVORCED single  
(Write the word)

<sup>6</sup> DATE OF BIRTH October 22<sup>nd</sup>, 1908  
(Month) (Day) (Year)

<sup>7</sup> AGE 21 yrs. 6 mos. 26 ds. or min. ?  
If LESS than 1 day.... hrs.

<sup>8</sup> OCCUPATION  
(a) Trade, profession or particular kind of work Stenographer  
(b) General nature of industry, business, or establishment in which employed or (employer) .....

<sup>9</sup> BIRTHPLACE (State or country) Baltimore, Md.

PARENTS

<sup>10</sup> NAME OF FATHER Michael J. Hunt

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Ireland

<sup>12</sup> MAIDEN NAME OF MOTHER Catherine G. Talvey

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) West Va.

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michael J. Hunt

(Address) 625 Aldershot Road

<sup>15</sup> Filed May 19 1930 C. H. Maule Registrar

MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH May 18<sup>th</sup>, 1930  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended the deceased from Aug 1929, to May 18, 1930.

that I last saw him alive on May 18, 1930.

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows:

Chronic suppurative Endocarditis

(Duration) 4 yrs. 10 mos. .... ds.

Contributory Secondary apoplexy

(Duration) .... yrs. .... mos. .... ds.

(Signed) J. M. Lempert M.D.

May 19 1930. (Address) 3409 Callaway

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

<sup>18</sup> LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

<sup>19</sup> PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Cathedral Ave May 21<sup>st</sup>, 1930

<sup>20</sup> UNDERTAKER ADDRESS

John J. Brown & Son 901 Holburn St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. (are should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Retired* (referred to *6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningea, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Præmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPARTAL septicæmia," "PERIPARTAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolving wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

0185

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 42Village or City Halters (No. Summit Ave)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Myrtle Margaret Hunter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)6 DATE OF BIRTH April 2, 1898  
(Month) (Day) (Year)7 AGE 31 yrs. 9 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Adam Miller11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Myrtle Amelia Gensler13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert A. Hunter(Address) Summit Ave15 Filed Jan 22 1930 Hes. McKeeff Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 15 1929 to Jan 20, 1930  
that I last saw her alive on Jan 18, 1930, and that death occurred on the date stated above, at 11:50 P.M.  
The CAUSE OF DEATH \* was as follows:Pulmonary Tuberculosis  
(Duration) 5 yrs. 5 mos. 5 ds.Contributory Secondary (Duration) 5 yrs. 5 mos. 5 ds.(Signed) William D. Pearson, M.D.  
121 1930 (Address) Halters

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Western Jan 24, 1930

20 UNDERTAKER ADDRESS

Wm Cook 1217 St Paul St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 2 1930

BUREAU



M. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

05277 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City Md Line (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Georganna Hutchins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Jan. 3, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 4 mos. 17 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework.  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) York Co Penna.

10 NAME OF FATHER William Hauptman

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Rachel Bantland

13 BIRTHPLACE OF MOTHER (State or country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Charles Hoffheiser

(Address) Maryland Line Md

15 Filed May 20 1930 Charles L. Egan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 20 1930 to May 20 1930, that I last saw him alive on May 20, 1930, and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH \* was as follows:

Myocardial Regurgitation

(Duration) 2 yrs. - mos. - ds.

Contributory Secondary Arterio Sclerosis.

(Duration) 3 yrs. - mos. - ds.

(Signed) J. Lyagle M. D.

May 20, 1930 (Address) New Freedom Pa.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Freedom Pa. May 22, 1930

20 UNDERTAKER ADDRESS

Hartenstein Monemakers Md Line Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Phoenix RFD No. RFD

2 FULL NAME Joshua Hutchins

0186

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 39

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Sept 20, 1898  
(Month) (Day) (Year)

7 AGE 87 yrs. 4 mos. 8 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Richard Hutchins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Matthews

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Charles Price  
(Address) Phoenix Md

15 Filed Jan 30 1930 Francis H. Blake  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from January 16 1930 to Jan 30, 1930  
that I last saw him alive on January 29, 1930,  
and that death occurred on the date stated above, at 7<sup>30</sup> a.m.  
The CAUSE OF DEATH \* was as follows:

Bronchitis Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.  
Contributory acute Schistosomiasis  
Secondary acute Pyelitis

(Signed) B. R. Benson M. D.  
Jan 30 1930 (Address) Cockeysville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St James Cemetery DATE OF BURIAL Feb 1, 1930

20 UNDERTAKER W. C. Brooks & Son ADDRESS Sparks Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

FEB 4 1930  
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			02104 STATE OF MARYLAND	
County <u>Baltimore</u>			CERTIFICATE OF DEATH	
Village or City <u>Woodlawn</u> (No. <u>Sumner Oak Ave</u> near <u>Windsor Mill Road</u> )			Registration Dist. No. <u>31</u>	
2 FULL NAME <u>Milton Iglehart</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widower</u> (Write the word)		
6 DATE OF BIRTH <u>Feb. 17</u> , 18 <u>36</u> (Month) (Day) (Year)				
7 AGE <u>94</u> yrs. <u>0</u> mos. <u>5</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Gardner</u> (b) General nature of industry business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Howard Co. Md</u>				
10 NAME OF FATHER <u>Edward Iglehart</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Howard Co Md</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Freddie Iglehart</u> (Address) <u>Woodlawn Md</u>				
15 Filed <u>2/22</u> 192 <u>3</u> <u>M. N. Buffler</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Feb. 22</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan. 29</u> , 19 <u>30</u> to <u>Feb. 22</u> , 19 <u>30</u> that I last saw him alive on <u>Feb 21</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>12:45</u> AM. The CAUSE OF DEATH * was as follows: <u>Chronic Myocardial Degeneration</u> (Duration) <u>Uncertain</u> yrs. mos. ds. Contributory Secondary <u>Senility</u> (Duration) yrs. mos. ds. (Signed) <u>Joshua H. Armacost</u> M. D. <u>Feb 22</u> , 19 <u>30</u> (Address) <u>Woodlawn Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Woodlawn Cem</u>			DATE OF BURIAL <u>Feb 24</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Armacost</u>			ADDRESS <u>4204 Ridgewood Ave</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonocum, etc., Coreinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." **Recommendations** on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Fulton (No. 31)

2 FULL NAME Charles H. Ishle

06477

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 43

Street Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb 25, 1899  
(Month) (Day) (Year)

7 AGE 31 yrs. 3 mos. 7 ds. or LESS than 1 day hrs. min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Plumber  
(b) General nature of industry, business, or establishment in which employed or (employer) Self

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER J. Frederick Ishle

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Kammer

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henrietta Ishle

(Address) Oran Ave. Fulton

15 Filed 6/6 1930 G. A. Fint  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 1, 1930 to June 5, 1930, that I last saw him alive on June 5, 1930, and that death occurred on the date stated above, at 11:55 A.M.

The CAUSE OF DEATH \* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. 7 mos. 26 ds.

Contributory Secondary (Duration) 2 yrs. 7 mos. 26 ds.

(Signed) R. Isaac M. D.

June 5, 1930 (Address) 3114 Wilkins Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL June 7th, 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		03991 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Lutherville</u> (No. <u>187-C</u> )		Registration Dist. No. <u>32</u>	
2 FULL NAME <u>John F. Iley</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>March 26, 1902</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>April 26<sup>th</sup>, 1930</u> (Month) (Day) (Year)	
7 AGE <u>28</u> yrs. <u>1</u> mos. <u>—</u> ds. or min.?		17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him <u>alive on</u> <u>192</u> , and that death occurred on the date stated above, at <u>—</u> m. The CAUSE OF DEATH * was as follows: <u>Fractured Skull resulting from automobile collision</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Chauffeur</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Private</u>		Contributory Secondary	
9 BIRTHPLACE (State or country) <u>Maryland</u>		(Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.	
PARENTS	10 NAME OF FATHER <u>John F. Iley</u>	(Signed) <u>Christopher J. Caroner, M.D.</u> <u>April 28, 1930</u> (Address) <u>Pikesville, Md.</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	Where was disease contracted, if not at place of death? Former or usual residence	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Elizabeth E. Iley</u> (Address) <u>Lutherville, Md.</u>			
15 Filed <u>1178</u> <u>30</u> <u>D. E. Nichols</u> Registrar		19 PLACE OF BURIAL OR REMOVAL <u>Woodlawn Cemetery</u> 20 UNDERTAKER <u>Chenoweth &amp; Sons</u> DATE OF BURIAL <u>Apr. 29, 1930</u> ADDRESS <u>3615 Chestnut St.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-pituitary fever* (the only definite synonym is "Epidemic cerebro-pituitary meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 5 1930

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

07768

(160)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Colgate (No. Woodrow Ave) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME John G. Imler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH July 9, 1930  
(Month) (Day) (Year)7 AGE \_\_\_\_\_ If LESS than 1 day, hrs. \_\_\_\_\_  
yrs. mos. 5 ds. or min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Balto. Md.10 NAME OF FATHER Wm H. Imler11 BIRTHPLACE OF FATHER (State or country) Honested Pa12 MAIDEN NAME OF MOTHER Virginia Lacey13 BIRTHPLACE OF MOTHER (State or Country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H. Imler(Address) Woodrow Ave15 Filed July 14, 1930 John G. Connell  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 9, 1930 to July 14, 1930  
that I last saw him alive on July 13, 1930  
and that death occurred on the date stated above, at 6:55 p.m.  
The CAUSE OF DEATH \* was as follows:Inanition

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Harry Wall M. D.  
July 14, 1930 (Address) Middle River, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mt Carmel Cem DATE OF BURIAL July 15, 193020 UNDERTAKER Geo M. Friedman ADDRESS 811 N W 4th

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED  
MAY 11 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto Co.

07769

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 12Village or City Parklee Station (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Fielder Ireland Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 ~~SINGLE~~ MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH May 24, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 1 mos. 14 ds. or \_\_\_\_\_ min.?  
IF LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Steam Hot Manufacturing  
(b) General nature of industry business, or establishment in which employed or (employer) W. S. Long Inc.

9 BIRTHPLACE (State or country) Calvert County - Maryland

10 NAME OF FATHER John Fielder Ireland

11 BIRTHPLACE OF FATHER (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Evelyn Parran

13 BIRTHPLACE OF MOTHER (State or Country) Calvert Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mattie Olivia Burger(Address) 20 Leeds Ave.

15 Filed July 9 1930 Geo. Sullivan  
Reg. tr.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1930  
(Month) 8 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 8, 1928 to July 8, 1930

that I last saw him alive on July 8, 1930

and that death occurred on the date stated above, at 2:00 P.M.  
The CAUSE OF DEATH \* was as follows:

Myocardial failure.

(Duration) \_\_\_\_\_ yrs. acute ds.

Contributory Cardio - Renal  
Secondary Apoplexy 3 hours

(Signed) James W. Wilson M. D.  
192 (Address) 1120 St Paul St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or \_\_\_\_\_ residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Smithville, Calvert Co. Md. 7/10, 1930

20 UNDERTAKER ADDRESS

Harry A. Witzke, 410 Edmondson Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Edgemere (No. 1)

2 FULL NAME Addie B. Jackson

05278

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Sal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH unknown

7 AGE about 60 yrs. 1 mos. 1 ds. or 1 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed or (employer) Spanaus Point

9 BIRTHPLACE (State or country)  Md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Bedford

(Address) Spanaus Point

15 Filed May 22, 1923

H. M. McCormick

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 17, 1923 to May 19, 1923

that I last saw him alive on May 18, 1923

and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Hemorrhage

Contributory  
Secondary

Pulmonary Tuberculosis (Duration) 1 yrs. 1 mos. 1 ds.

(Signed) H. M. McCormick M. D.  
May 22, 1923 Address Spanaus Point

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Green Willow Cem

DATE OF BURIAL

May 22, 1923

20 UNDERTAKER

Mrs. R. A. Elliott

ADDRESS

Baeto



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic, valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE

FAIRLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

07710

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 47Village or City Turners Sta. (No.       )Pay FrontSt.       Ward       

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Andrew Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7 AGE

22 yrs.       mos.       ds.If LESS than  
1 day        hrs.  
or        min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of workLaborer(b) General nature of industry  
business, or establishment in  
which employed or (employer)Bethlehem Steel Co.

9 BIRTHPLACE

(State or country)

North Carolina.10 NAME OF  
FATHERBrack Jackson11 BIRTHPLACE  
OF FATHER

(State or country)

North Carolina.12 MAIDEN NAME  
OF MOTHERHattie Bass.13 BIRTHPLACE  
OF MOTHER

(State or Country)

North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph R. Alston(Address) 1725-E-Edgar St. Balto. Md

15

Filed 7/13/30Registrar Wm. J. Connolly

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 12th 1930, 192(Month)        (Day)        (Year)       

17

I HEREBY CERTIFY, That I attended the deceased from

192 to       , 192      that I last saw him        alive on       , 192      and that death occurred on the date stated above, at        m.

The CAUSE OF DEATH \* was as follows:

Accidental Drowning(Duration)        yrs.        mos.        ds.Contributory  
Secondary(Duration)        yrs.        mos.        ds.(Signed) Frederick J. Adams M. D.7/13 19230 (Address)       \*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death        yrs.        mos.        ds.In the  
State        yrs.        mos.        ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence       

19 PLACE OF BURIAL OR REMOVAL

Pittletown N.C.

DATE OF BURIAL

7/14/30

20 UNDERTAKER

J. J. Connolly

ADDRESS

Esse X

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Seaman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, vertigoceum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

14689

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville (No. 56 Winter Ave.)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME in- stead of street and number.)

2 FULL NAME Hariett E. Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Mar = 9 = 1856  
(Month) (Day) (Year)

7 AGE 74 yrs. 9 mos. 16 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Sprieggs

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Margaret Jackson

(Address) 7216 Druid Hill Ave.

15 Filed Dec 29 1930 B. M. Haffey Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec = 27 = 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 4 1930 to Dec 24 1930

that I last saw her alive on Dec 24 1930

and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH \* was as follows:

Uremia  
Valvular Disease of Heart  
and Nephritis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 20 ds.

Contributory Valvular Disease of  
Secondary Heart & Nephritis (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 20 ds.

(Signed) Thos. M. Haffey M. D.

Dec 29 1930 (Address) 703 W. Poplar St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence. \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL White Rock Cemetery DATE OF BURIAL Dec = 30 = 1930

20 UNDERTAKER B. M. Haffey ADDRESS Winfield, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data essential and must be obtained before the certificate is permanently filed.

JAN 5 1931  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

06478

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43Village or City Fullerton (No. Hearne Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Henry Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH <u>Dec. 25, 1853</u> (Month) (Day) (Year)
---

7 AGE <u>76 yrs. 5 mos. 29 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
---------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____
--

9 BIRTHPLACE (State or country) <u>Maryland</u>
--

10 NAME OF FATHER <u>Unknown</u>
-------------------------------------

11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>
--

12 MAIDEN NAME OF MOTHER <u>Unknown</u>
--

13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>
--

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace Jackson(Address) Fullerton Md15 Filed 6/27 1930 G. A. Fitz

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 17, 1930 to June 24, 1930  
that I last saw him alive on June 24, 1930  
and that death occurred on the date stated above, at 4 P. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral apoplexy

Contributory Secondary	(Duration) yrs. ____ mos. ____ ds.
---------------------------	------------------------------------

(Signed) Samuel A. Jones M. D.  
June 27, 1930 (Address) 5631 Westford Rd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.	In the State ____ yrs. ____ mos. ____ ds.
--	---

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Capwood Cemetery</u>	DATE OF BURIAL <u>June 28, 1930</u>
--	--

20 UNDERTAKER <u>Fred L. Lashburn</u>	ADDRESS <u>Fullerton</u>
--	-----------------------------

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mescalies*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mescalies* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 1 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County *Baltimore*

Village or City *Cockeysville MD* (No. *114*)

2 FULL NAME *James Wesley Jackson*

07151 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *37*

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *November 27, 1889*  
(Month) (Day) (Year)

7 AGE *70 yrs. 7 mos. 3 ds.* If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work *Farmer*  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) *Balto Co., Md.*

10 NAME OF FATHER *Benjamin Jackson*

11 BIRTHPLACE OF FATHER (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Southern Benson*

13 BIRTHPLACE OF MOTHER (State or Country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. James W. Jackson*  
(Address) *Cockeysville Md*

15 Filed *July 3, 1930* *B R Benson M.D.* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 30, 1930*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from *June 27, 1930* to *June 30, 1930*  
that I last saw him alive on *June 30, 1930*

and that death occurred on the date stated above, at *5:45* m.

The CAUSE OF DEATH \* was as follows:  
*Acute Yellow Infection*

(Duration) \_\_\_\_ yrs \_\_\_\_ mos *3* ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

(Signed) *Dr. R. Benson* M. D.  
*June 30, 1930* (Address) *Cockeysville Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds. In the State \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Arcadia (St Pauls)* DATE OF BURIAL *July 3, 1930*

20 UNDERTAKER *Wm. C. Brooks & Son Sparks, Md* ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: ( *cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia, ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent, affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—cardiac acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

AUG 6 1930  
BUREAU V. 3.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PARTICULARLY, and EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

Sheppard and Enoch Pratt Hospital

Village or City Towson

(No. \_\_\_\_\_)

Maryland

St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration Dist. No. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Miss Mary Cecelia Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH

September 17 1870  
(Month) (Day) (Year)

7 AGE

60 yrs. — mos. 13 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore, Maryland

10 NAME OF

FATHER

John S. Jackson

11 BIRTHPLACE

OF FATHER

(State or country) Baltimore, Maryland

12 MAIDEN NAME

OF MOTHER

Mary Cecelia Pickering

13 BIRTHPLACE

OF MOTHER

(State or country) Baltimore, Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address)

15 Filed

Oct 14 1930John P. Butler  
Registrar

12198

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 14, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

August 27, 1930 to October 14, 1930that I last saw her alive on October 13, 1930and that death occurred on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH \* was as follows:

Suicide by drowningContributory  
SecondaryManic depressive psychosis,  
depressed phase.

(Signed)

Arthur E. Pattrell, M.D.October 14, 1930 (Address) Towson, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 1 mos. 17 ds. In the State yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 214 N. Calhoun St., Baltimore

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Landon Park, cum Oct. 16, 1930

20 UNDERTAKER

ADDRESS

Geo. W. Tuttle 722 Windsor



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer over 60 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiopathic fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU

RECEIVED

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD  
 Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
 County Baltimore

Village or City Ruston (No. Boyce Ave St. Hannic Ward)

2 FULL NAME Fannie Rider Jackson

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow  
 (Write the word)

6 DATE OF BIRTH Aug 10<sup>th</sup> 1849  
 (Month) (Day) (Year)

7 AGE 80 yrs. 11 mos. 1 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
 (a) Trade, profession or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Salisbury Md

10 NAME OF FATHER Wm H. Rider

11 BIRTHPLACE OF FATHER (State or country) Salisbury Md

12 MAIDEN NAME OF MOTHER Margaret Rider

13 BIRTHPLACE OF MOTHER (State or country) Salisbury Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard N. Jackson  
 (Address) Stevenson Md.

15 Filed July 12 1930 Wm P Butler  
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11 1930  
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from Mar 20 1930 to July 11 1930, that I last saw her alive on July 11 1930, and that death occurred on the date stated above, at 7-50 P.M.

The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia (Terminal)  
Complete Anoxia

Contributory Secondary Chronic Myocarditis  
 (Duration) yrs. 1 1/2 ds.

(Signed) M. Gibson Porter M. D.  
7/12 1930 (Address) 4822 Roland Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Salisbury Md DATE OF BURIAL July 14 1930

20 UNDERTAKER Henry J. Jenkins Inc ADDRESS McCallor & Co

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. 601.

\* Perm. file 10/9/42 L

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

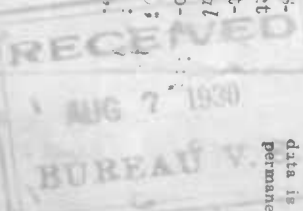
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Coal engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto</u>			02637 (202)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rustons</u> (No. <u>MD</u> )			St. <u>MD</u>		Registration Dist. No. <u>33</u>	
2 FULL NAME <u>Thomas C. Jackson</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)				
6 DATE OF BIRTH <u>unknown</u> (Month) (Day) (Year)						
7 AGE <u>about 16</u> yrs. <u>—</u> mos. <u>—</u> ds. or <u>—</u> min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>England</u>						
10 NAME OF FATHER <u>Thomas Jackson</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>England</u>						
12 MAIDEN NAME OF MOTHER <u>unknown</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>—</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Hattie Tinkler</u> (Address) <u>Rustons MD</u>						
15 Filed <u>Mar 23</u> 19 <u>30</u> <u>at Rustons</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>unknown</u> 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>—</u> , 19 <u>2</u> , that I last saw him <u>—</u> alive on <u>—</u> , 19 <u>2</u> , and that death occurred on the date stated above, at <u>—</u> m.						
The CAUSE OF DEATH* was as follows: <u>accidental by tree falling on him - last seen Monday</u> <u>March 17 - found under a fallen tree Sunday March 23/1930</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.						
Contributory Secondary <u>Robert H. Lortie</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>March 24</u> 19 <u>30</u> (Address) <u>Rustons MD</u> M. D.						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>—</u>						
19 PLACE OF BURIAL OR REMOVAL <u>Asbury M &amp; Cemetery</u>				DATE OF BURIAL <u>Mar 24, 1930</u>		
2D UNDERTAKER <u>Rustons MD</u>				ADDRESS <u>J. F. Eline Rustons MD</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential) and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 7 1900  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			02638 STATE OF MARYLAND CERTIFICATE OF DEATH		Registration Dist. No. 38
County <u>Baltimore</u>			(90)		
Village or City <u>Edlewylder</u> (No. _____)			St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Fredericks Jacob</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>March 5</u> , 19 <u>30</u> . (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Nov. 22</u> , 18 <u>53</u> . (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Oct. 25</u> , 192 <u>9</u> , to <u>March 5</u> , 19 <u>30</u> , that I last saw him alive on <u>March 5</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8:25</u> A.M. The CAUSE OF DEATH * was as follows: <u>Apoplexy</u> <u>Chronic Interstitial Nephritis</u>		
7 AGE <u>76</u> yrs. <u>3</u> mos. <u>17</u> ds. or min.?			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)			(Duration) _____ yrs. <u>4</u> mos. <u>11</u> ds.		
9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u>			Contributory Secondary <u>Arterio-sclerosis</u> <u>Chronic Myocarditis</u> (Duration) <u>4</u> yrs. _____ mos. _____ ds.		
10 NAME OF FATHER <u>John Jacob</u>			(Signed) <u>W. G. Cole</u> M. D.		
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>			<u>March 5</u> , 19 <u>30</u> (Address) <u>6014 York Rd. Balto. Md.</u>		
12 MAIDEN NAME OF MOTHER <u>Wilhelmina Huntscha</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Louise Jacob</u> (Address) <u>6511 Maplewood Rd.</u>			Where was disease contracted, if not at place of death? Former or usual residence _____		
15 Filed <u>Mar 7</u> 19 <u>30</u> <u>Edlewylder</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Loudon Park</u>		
			20 UNDERTAKER <u>John F. Denny</u>		
			DATE OF BURIAL <u>March 7</u> , 19 <u>30</u>		
			ADDRESS <u>7152 15th St</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonocum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked thoroughly and all questions answered in detail, it will require no further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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PLACE OF DEATH

County

Baltimore

07152

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

44

Village or City

Burr Point

(No.)

194

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Benjamin Jacobs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

12

(Month)

25

(Day)

1910

(Year)

7 AGE

19

yrs.

6

mos.

4

ds.

If LESS than

1 day

hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Chemist

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore, Md.

10 NAME OF FATHER

Abraham Jacobs

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Annie Kanel

13 BIRTHPLACE OF MOTHER

(State or Country)

Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Vogel

(Address)

400 E. Federal St

15

Filed

July 1

1932

John O. Connelly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6 -

29

1930

6

(Month)

29

(Day)

(Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from

192

to

192

that I last saw him alive on

192

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Accidental Drowning

Contributory Secondary

(Duration)

yrs.

mos.

ds.

(Signed) Thomas R. Brown, M.D.  
Edgemoor, 192 (Address) 1210 Box 98 Edgemoor, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the

State

yrs.

mos.

ds.

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John Henry Brown

7-2-30, 19

20 UNDERTAKER

ADDRESS

Jacob Lewis, 1419 E. Baltimore St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

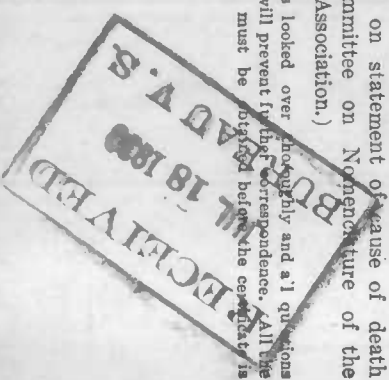
(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Spurris Point (No. 161-a)

2 FULL NAME Mercedes May James

12199 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. James Beck Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 24<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or 30 min. If LESS than 1 day, \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Spurris Point

10 NAME OF FATHER John William James

11 BIRTHPLACE OF FATHER (State or country) Spurris Point

12 MAIDEN NAME OF MOTHER Mercedes May Ferguson

13 BIRTHPLACE OF MOTHER (State or Country) Charles Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. James  
(Address) Spurris Point

15 Filed Oct 25, 1930 H. H. McCormick, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 24<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 24<sup>th</sup>, 1930, to Oct 24<sup>th</sup>, 1930, that I last saw him alive on Oct 24<sup>th</sup>, 1930,

and that death occurred on the date stated above, nt \_\_\_\_\_ m. The CAUSE OF DEATH \* was as follows:

Premature 7 months

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Frank C. Edmund M. D.  
192\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Oak Lawn An DATE OF BURIAL Oct 27, 1930

20 UNDERTAKER Parents. ADDRESS James Creek



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 8 1930

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Baltimore

06479

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 32Village or City Green Spring Valley (No. "Seven Oaks") St.;        Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Carrell Jenkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)
----------------------	---------------------------------	---

6 DATE OF BIRTH

October 15, 1835, 1  
(Month) (Day) (Year)

7 AGE

94 yrs. 7 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Retired(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9 BIRTHPLACE (State or country)

Baltimore, Md.

## PARENTS

10 NAME OF FATHER

Thomas C. Jenkins

11 BIRTHPLACE OF FATHER (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Louisa Carroll

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Thomas Courtney Jenkins (son)(Address) Green Spring Valley, Md.

15

Filed June 6, 1930 SO & EE McPhae  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 5<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

      , 1910 to June 5<sup>th</sup>, 1930that I last saw him alive on June 5<sup>th</sup>, 1930and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH\* was as follows:

Infarction of apex  
Terminal left heart trouble  
pneumonia  
(Duration)        yrs.        mos. 1 ds.Contributory  
Secondary(Duration)        yrs.        mos.        ds.(Signed) Thomas R. Brown, M. D.June 6, 1930 (Address) 12 E. Egan H.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted,

If not at place of death?

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral CemeteryJune, 7, 1930, 191

20 UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scullie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Baltimore*

Village or City

*Middle River*

(No. \_\_\_\_\_)

2 FULL NAME

*Joseph H. Jenkins*STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*44*

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Married*

6 DATE OF BIRTH

*Jan. 28, 1868*  
(Month) (Day) (Year)

7 AGE

*62 yrs. 9 mos. 19 ds.*  
If LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Retired Merchant*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Balto. Co. Maryland*

10 NAME OF FATHER

*William T. Jenkins*

11 BIRTHPLACE OF FATHER

(State or country)

*Balto. Co. Maryland*

12 MAIDEN NAME OF MOTHER

*Catherine Bartler*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Balto. Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Elizabeth H. Jenkins*

(Address)

*Middle River*

15 Filed

*Nov. 18, 1930**John J. Connolly*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Nov. 17, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Nov. 17, 1930* to *Nov. 17, 1930*that I last saw him alive on *Nov. 17, 1930*and that death occurred on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH \* was as follows:

*Cerebral Hemorrhage*Contributory  
Secondary*Stroke*  
(Duration) yrs. mos. ds.  
(Signed) *C. J. Wade* M. D.  
(Address) *192*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cemetery Nov. 19, 1930*

20 UNDERTAKER

ADDRESS

*Frederick L. Lachman 7401 Belair Rd.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operations was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 5 1930

BU



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

14690

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Middle River (No. 172 Kingston Park SL: 101-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret R. Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Oct. 25, 1856  
(Month) (Day) (Year)

7 AGE 74 yrs. 2 mos. — ds. or — min. ?  
If LESS than 1 day... hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer) At Home

9 BIRTHPLACE (State or country) Baltimore Co. Md

PARENTS  
10 NAME OF FATHER Charles Donnelly  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Agnes E. Through  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Agnes E. Ashley  
(Address) 839 N. Fulton Ave

15 Filed Dec. 26, 1930 Thos. J. Donnelly  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 19, 1930, to Dec 25, 1930, that I last saw her alive on Dec 25, 1930, and that death occurred on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH was as follows:  
Lobar Pneumonia  
(Duration) 6 yrs. — mos. — da.

Contributory Secondary  
(Duration) — yrs. — mos. — da.  
(Signed) J. J. Fisher M. D.  
Dec 26, 1930 (Address) Essex Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs. ... mos. ... da. In the State... yrs. ... mos. ... da.  
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western DATE OF BURIAL Dec. 27, 1930

20 UNDERTAKER Horace F. Burgee ADDRESS 3631 Falls Road

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insultion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Baltimore03992 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 33Village or City near Sydenham (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME rest name

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Apr 8, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day 4 hrs. \_\_\_\_\_  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry business, or establishment in which employed or (employer) Home9 BIRTHPLACE (State or country) Ind10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (State or country) unknown12 MAIDEN NAME OF MOTHER Caroline Jenkins13 BIRTHPLACE OF MOTHER (State or Country) Ind

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Caroline Jenkins(Address) Baltimore

15 Filed Apr. 12 1930 rest name  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 8 1930 to Apr. 8 1930,  
that I last saw him alive on Apr 8, 1930,

and that death occurred on the date stated above, at 2 P m.  
The CAUSE OF DEATH \* was as follows:

Organic  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## Contributory Secondary

(Signed) rest name M. D.  
Apr. 8 1930 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

G. G. HouseApr. 8, 1930

## 20 UNDERTAKER

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 6 1930

BUREAU V. S.

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1 PLACE OF DEATH  
County Baltimore

14691

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 37

Village or City Cockeysville Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Bettie Austin Jessop

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan. 21, 1920  
(Month) (Day) (Year)

7 AGE 10 yrs. 10 mos. 21 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cockeysville Md.

10 NAME OF FATHER W. Harry Jessop  
11 BIRTHPLACE OF FATHER (State or country) Cockeysville, Md.  
12 MAIDEN NAME OF MOTHER Virginia Stokes  
13 BIRTHPLACE OF MOTHER (State or country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Harry Jessop

(Address) Cockeysville, Md.

15 Filed Dec 12 1930 B. B. Bennett Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1923 to Dec 12, 1930, that I last saw him alive on Dec 12, 1930, and that death occurred on the date stated above, at 3 P m. The CAUSE OF DEATH \* was as follows:

Myocarditis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) B. B. Bennett M. D.  
Dec 12, 1930 (Address) Cockeysville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sherrwood P. E. Cemetery

Dec. 15, 1930

20 UNDERTAKER

ADDRESS

H. W. Meunier

805 N. Calvert St.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Libiobacteria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 8 1931

BUR

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

12200

(159-8)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Eccleston (No. 12200) Park Heights Ave. St. 12200 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Kathyrine Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, OR DIVORCED Inf.  
(Write the word)

6 DATE OF BIRTH Sept. 30 Oct. 5 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. 4 da. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Eccleston

10 NAME OF FATHER Howard Johnson

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Kathyrine Boyd

13 BIRTHPLACE OF MOTHER (State or Country) Balto Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Boyd  
(Address) Eccleston Md.

15 Filed Oct 6 - 1930 E E Nichols  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5, 1930 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 30 1930 to Oct 5 1930, that I last saw her alive on Oct 5 1930

and that death occurred on the date stated above, at 5 A m.

The CAUSE OF DEATH \* was as follows:  
Failure of renal valves  
close

(Duration) yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) G. H. Buckley M. D.  
Oct 5 1930 (Address) 3337 Belvidere Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Michaels Cemetery DATE OF BURIAL Oct 6 1930

20 UNDERTAKER Frank H. Purcell ADDRESS Pikesville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930  
BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Baltimore (No. \_\_\_\_\_)

2 FULL NAME John W. Johns

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH March 5 1873  
(Month) (Day) (Year)

7 AGE 15-7 3 mos 7 1/2 If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Matthews

(Address) Baltimore

15 Filed June 30 1930 John W. Connelly Registrar

06480

193

14a

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_ to \_\_\_\_\_ 192\_\_

that I last saw him alive on \_\_\_\_\_ 192\_\_

and that death occurred on the date stated above, at 2:24 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage  
(Duration) 8 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Chas. E. Post M. D.  
June 30 1930 Address Edgewood

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. James Church DATE OF BURIAL July 1 1930

20 UNDERTAKER Harmon W. Smith ADDRESS 700 North Connelley

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

01390

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 31

Village or City Randallstown No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lora Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C. 5 SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Aug 15, 1889

7 AGE 40 yrs. 5 mos. 20 ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or min.?

8 OCCUPATION

- (a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF  
FATHER Jos. Davis

11 BIRTHPLACE  
OF FATHER Maryland

12 MAIDEN NAME  
OF MOTHER Caroline Bell

13 BIRTHPLACE  
OF MOTHER Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis Johnson

(Address) Randallstown

15 Filed 2/5 1930 H. F. Shipley Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 5, 1930

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1, 1930 to Feb. 5, 1930, that I last saw her alive on Feb. 4, 1930, and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH \* was as follows:

Tuberculosis of lungs  
unknown

Contributory  
Secondary

(Signed) Wm. E. Martin M. D. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Feb. 5, 1930 (Address) Randallstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Union Bchrl

DATE OF BURIAL Feb 7, 1930

20 UNDERTAKER H. Hensley

ADDRESS W. Biddle St. Balt. Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labour pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 4 1904

BUREAU V. S.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

12201

## CERTIFICATE OF DEATH. 99

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Chesapeake Ave. Towson Md ST. Towson WARD)REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Johnson(a) RESIDENCE NO. 124 Chesapeake Ave. Towson Md ST. Towson WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred L. yrs. mos. ds.L. yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE C5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Johnson6 DATE OF BIRTH (month, day, and year) 1872 unknown7 AGE 62 Years Months Days

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Towson Md (State or country)10 NAME OF FATHER Frank Johnson11 BIRTHPLACE OF FATHER (city or town) Md (State or country)12 MAIDEN NAME OF MOTHER Hester Howard13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14

Informant (Address) Carrie Johnson  
124 Chesapeake Ave. Towson Md

15

Filed Oct 5 1930 W. P. C. B. L. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4, 30.

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to Oct 3, 1930.that I last saw him alive on Oct 3, 1930.and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH\* was as follows:

Myocardial Recompensation(duration) 2 yrs. mos. ds.CONTRIBUTORY (Secondary) Arthur Blum(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Thurston M. D.Oct 30 (Address) Towson Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Pleasant Rest Cem.

DATE OF BURIAL

10-7-1930

20 UNDERTAKER

ADDRESS

Byron Wright 218 Mc & Berry St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter*; *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farther (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name ori-

gin "Cancer" is less definite). Avoid use of "Typhoid" for malignant neoplasms; *Measles*; *Whooping cough*, *chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congestial," "Senile," etc., "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

NOV-6-1930  
BUREAU V 6

06033

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 31

1 PLACE OF DEATH

County BaltimoreVillage or City Randallstown No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Georgia Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 24, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Clayton Johnson11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Georgia Beckett13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clayton Johnson(Address) Randallstown15 Filed 5/24 1930 M. H. Buffert Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from May 22, 1930 to May 24, 1930  
that I last saw him alive on May 23, 1930,  
and that death occurred on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH \* was as follows:

Patient foramen orale  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) John E. Martin M. D.  
May 24, 1930 Address Randallstown

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. View Cemetery May 25, 1930

20 UNDERTAKER ADDRESS

Weir & Son & Sykesville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (metely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 2 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			Registration Dist. No. <u>20</u>	
Village or City <u>Reisterstown</u> (No. <u>MD</u> )			St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Harry F. Johnson</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>Jan 6, 1930</u> (Month) (Day) (Year)				
7 AGE <u>11</u> yrs. <u>10</u> mos. <u>20</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Baltimore, Co. MD</u>				
PARENTS	10 NAME OF FATHER <u>Carroll Johnson</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore Co. MD</u>			
	12 MAIDEN NAME OF MOTHER <u>Sue Johnson</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Baltimore Co. MD</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Maggie Johnson</u> (Address) <u>Reisterstown MD</u>				
15 Filed <u>Dec 26, 1930</u> <u>80mbeats</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Dec 24, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 15, 1930</u> to <u>Dec 24, 1930</u> , that I last saw him alive on <u>Dec 24, 1930</u> , and that death occurred on the date stated above, at <u>20</u> m. The CAUSE OF DEATH * was as follows: <u>Broncho Pneumonia, following a bronchitis. Cough.</u>				
(Duration) _____ yrs. _____ mos. <u>9</u> ds.				
Contributory <u>Rickets</u> Secondary _____				
(Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>James P. Saffell</u> M. D. <u>12-26-1930</u> (Address) <u>Reisterstown Md</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.				
Where was disease contracted, if not at place of death? _____				
Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>St. Lukes Cemetery</u>				DATE OF BURIAL <u>Dec 26, 1930</u>
20 UNDERTAKER <u>F. E. Collins Reisterstown</u>				ADDRESS _____

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

JAN 5 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Imanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE

WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

Village or City

Sparks St. (No. 817)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Hypernia Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C.

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

June 10, 1914

7 AGE

16 yrs. 6 mos. ds. or min. ?

If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

School girl

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec 26, 1923, L. M. Johnson, M.D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 22, 1930

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1, 1930, to Dec 22, 1930

that I last saw him alive on Dec 22, 1930, and that death occurred on the date stated above, at 9 P.m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

Contributory  
Secondary(Signed) J. M. Johnson, M.D.  
12/26/30 (Address) 817 Sparks St. Balto.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. .... mos. .... da. In the State.... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cashing County Dec 26, 1930

20 UNDERTAKER

ADDRESS

Mrs. R. A. Elliott 1725 Ashland Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

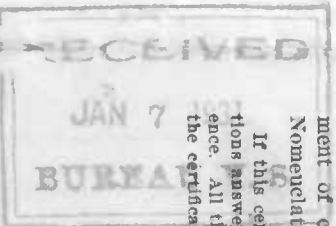
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City Chesaco Park (No. 15th Dist.)

2 FULL NAME John Johnson

234 13563 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Nov. 4, 1892  
(Month) (Day) (Year)

7 AGE 38 yrs. 0 mos. 0 ds. or 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) N. Carolina

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) ?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wattie Johnson

(Address) 802 M. Monmouth St

15 Filed Nov. 5, 1930 John G. Connolly  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920

that I last saw him alive on 1920

and that death occurred on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH \* was as follows:

Struck by Penn. R.R. Train  
#104; unavoidable accident  
(Duration) 0 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.  
(Signed) Jacob Hallman, Coroner M. D.  
1920 (Address) Stammers Run

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL mt Calvary DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER Mrs. R. Elliott ADDRESS 1725 Ashland Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operations was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930  
BUREAU V. B.

MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

01391

(180)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Sparrows Point Md (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John B. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ✓

6 DATE OF BIRTH April 25, 1891  
(Month) (Day) (Year)

7 AGE 37 yrs. 9 mos. 22 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work School  
(b) General nature of industry, business, or establishment in which employed or (employer) Maryland Hay Co.

9 BIRTHPLACE (State or country) Groesbeek Co. Va

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (State or country) Groesbeek Co. Va

12 MAIDEN NAME OF MOTHER Julia Robinson

13 BIRTHPLACE OF MOTHER (State or Country) Groesbeek Co. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John Robinson  
(Address) 1044 7th Ave. N.Y.

15 Filed Feb. 19th 1930 M. J. McMichael Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended the deceased from death to life and death occurred on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH \* was as follows:  
accidental suffocation by plug dust.

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) John W. Nichols M.D. 7/17 1930 (Address) Sparrows Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Labot Rd DATE OF BURIAL 2/20 1930

20 UNDERTAKER Samuel T. Hunsley ADDRESS 178 St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU OF

MARGIN RESERVED FOR BINDING  
WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.Village or City Sparrows Point (No. 610. Eye)2 FULL NAME Martha JohnsonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE C 5 SINGLE 24  
MARRIED.  
WIDOWED.  
OR DIVORCED  
(Write the word)6 DATE OF BIRTH Aug 5, 1890  
(Month) (Day) (Year)7 AGE 40 yrs. 0 mos. 13 ds. or min.?  
If LESS than 1 day hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Va10 NAME OF FATHER Dr. Coleman11 BIRTHPLACE OF FATHER (State or country) Va12 MAIDEN NAME OF MOTHER Martha Jones13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Johnson(Address) 610. Eye15 Filed Aug 19 1923 W. H. McMichael  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 15, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended the deceased from Aug 12 1920 to Aug 15 1920that I last saw him alive on Aug 15, 1920

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Broncho pneumoniaContributory  
Secondary (Duration) yrs. mos. ds.(Signed) L. N. Toller M. D.  
Aug 16 1920 (Address) Spar. Pt. Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Notary Aug 19, 1920

20 UNDERTAKER ADDRESS

Sam. Chase 1400 Market



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH,  
County Baltimore

Village or City Cockeysville RFD (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME Mary Johnson

Registration Dist. No. 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_

6 DATE OF BIRTH Dec 18 1930  
(Month) (Day) (Year)

7 AGE Still Birth (If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?)

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mildred Marie Howard

13 BIRTHPLACE OF MOTHER (State or country) Balti, Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Johnson (Father)

(Address) Cockeysville Ind

15 Filed Dec 18<sup>th</sup> 1930 J. A. Drach M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 17<sup>th</sup> (in Utero) 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 16<sup>th</sup> 1930 to Dec 17<sup>th</sup> 1930.

that I last saw her or alive on Dec 16<sup>th</sup> 1930.

and that death occurred on the date stated above, at about 11 P.M. (in Utero)

The CAUSE OF DEATH \* was as follows:

not known - Probably due to  
Contracted Pelvic Chancr delay in  
Delivery

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Difficult Forceps Delivery

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.

(Signed) John H. Drach M. D.

Dec 18<sup>th</sup> 1930 (Address) Cockeysville Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Goughs Chapel Cmt Dec 19<sup>th</sup> 1930

20 UNDERTAKER ADDRESS

John Johnson Father of Chas Cockeysville Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet fever* (never report "Typhoid Pneumonia"); *Scarlet pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 8 1901

BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH County <u>Balto.</u>		13564		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Towson</u> (No. <u>427</u> )		St. <u>Anna. Cir.</u>		Registration Dist. No. <u>31</u>	
2 FULL NAME <u>Mary Ann Johnson</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)			
6. DATE OF BIRTH <u>Unknown</u> , 1850 (Month) (Day) (Year)					
7. AGE <u>80<sup>+</sup></u> yrs. mos. ds. or min. If LESS than 1 day hrs.					
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Cook</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>Dr. M. E. Curdy</u>					
9. BIRTHPLACE (State or country) <u>MD</u>					
10. NAME OF FATHER <u>Unknown</u>					
11. BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>					
12. MAIDEN NAME OF MOTHER <u>Unknown</u>					
13. BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Dr. M. E. Curdy</u> (Address) <u>618 York Road</u>					
15. Filed <u>Nov 11 1930</u> Registrar <u>James Newsly Biddle</u>					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>Nov 8</u> , 192 <u>30</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended the deceased from <u>Nov. 1</u> , 192 <u>30</u> to <u>Nov 8</u> , 192 <u>30</u> that I last saw him <u>alive</u> on <u>Nov 8</u> , 192 <u>30</u> and that death occurred on the date stated above, at <u>4 P. M.</u> The CAUSE OF DEATH * was as follows: <u>Chronic Vascular Heart Disease</u> (Duration) <u>2</u> yrs. mos. ds.					
Contributory Secondary (Signed) <u>Dr. M. E. Curdy</u> M. D. <u>Nov. 11 1930</u> (Address) <u>2629 Guilford L.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL <u>Crestmont Cemetery</u> DATE OF BURIAL <u>Nov 12 1930</u>					
20. UNDERTAKER <u>James Newsly Biddle</u> ADDRESS <u>578</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, whether engaged in the duties of the household only or not paid housekeepers who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data are essential and must be obtained before the certificate is permanently filed.

DEC 6 1930

BUREAU



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

172 03993  
(90)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Cessex (No. Myrtle Ave. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Margaret Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. 21<sup>st</sup>, 1866  
(Month) (Day) (Year)

7 AGE 63 yrs. 5 mos. 24 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Lud. Reinhardt

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Smith

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd C. Johnson

(Address) Myrtle Ave.

15 Filed Apr. 18 1930 John G. Connelly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 15 1930 to Apr 15, 1930, that I last saw her alive on Apr 15, 1930.

and that death occurred on the date stated above, at 11:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

Contributory (Duration) 5 yrs. mos. ds.

Secondary Acute Corditis 30 min.  
Reluctant (Duration) hrs. mos. ds.

(Signed) James F. White M. D.  
Apr 17 1930 (Address) Cessex, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death hrs. mos. ds. In the State hrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 4/18/1930

20 UNDERTAKER John G. Connelly ADDRESS Cessex

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

01392

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 39Village or City Singh (No. 10 St. 10 Ward 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Robert J. Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

March 1, 1880  
(Month) (Day) (Year)

7 AGE

54 yrs. 4 mos. 4 ds. or 1 min. ?  
If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

King

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. H. Brown(Address) Pharmacy, Baltimore

15

Filed 4/25/30 192 Francis A. Blake  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 23, 1934  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb 20, 1934, to Feb 23, 1934  
that I last saw him alive on Feb 20, 1934, 1934and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH was as follows:

Heart Disease(Duration) 2 yrs. 5 mos. 4 ds.Contributory  
SecondaryHeart Disease (Duration) 2 yrs. 5 mos. 4 ds.(Signed) Dr. J. H. Brown M.D.Feb 24, 1934 (Address) 600 York St. Baltimore

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Feb 26, 1934

20 UNDERTAKER

ADDRESS BaltimoreDr. J. H. Brown Singh

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemic," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1930  
BUREAU V. D.

MARGIN RESERVED FOR BINDING

V. S. No. 1

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			077712		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Butler</u> (No. _____)			(182)		Registration Dist. No. <u>37</u>	
2 FULL NAME <u>William Henry Johnson Jr</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>Jan 31 1917</u> (Month) (Day) (Year)						
7 AGE <u>13 yrs. 5 mos. 16 ds.</u> IF LESS than 1 day hrs. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Balt Co Md</u>						
PARENTS	10 NAME OF FATHER <u>Wm Henry Johnson</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Balt Co Md</u>					
	12 MAIDEN NAME OF MOTHER <u>Nancy Elizabeth Smith</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Balt Co Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William Henry Johnson</u> (Address) <u>Butler Md</u>						
15 Filed <u>July 18 1920</u> <u>J. H. Drachmond</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>July 17th 1920</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>1920</u> to <u>1920</u> , that I last saw him alive on _____, 1920, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows: <u>Sudden death by drowning</u> <u>Saw Corpse immediately after death</u> <u>J. H. Drachmond</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Not mentioned</u> Physician _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>W. P. Butler</u> (Coroner) M. D. <u>July 17 1920</u> (Address) <u>Lawson, Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Gough M. E. Cemetery</u>				DATE OF BURIAL <u>July 19th 1920</u>		
20 UNDERTAKER <u>Wm. C. Brooks</u>				ADDRESS <u>Sparks Md</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City White Hall (No. \_\_\_\_\_)

2 FULL NAME Seven month stillborn Johnson

02639 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 35

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME, extend of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single  
6 DATE OF BIRTH March 1, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) White Hall Balto

10 NAME OF FATHER Harry Daniel Johnson

11 BIRTHPLACE OF FATHER (State or country) Balto City Md.

12 MAIDEN NAME OF MOTHER Eedna May Brownell

13 BIRTHPLACE OF MOTHER (State or Country) Balto Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert J. Johnson

(Address) White Hall Md.

15 Filed May 1, 1930 M. B. B. B.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1, 1930 to March 1, 1930  
that I last saw him on March 1, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Iues

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Albert J. Johnson M. D.  
March 1, 1930 (Address) White Hall Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL On Green DATE OF BURIAL May 1, 1930

20 UNDERTAKER Harry D. Johnson ADDRESS White Hall

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930

BU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATH

08973

198

Registration Dist. No.

38

Village or City Towson (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Baby Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Aug 25, 1930  
(Month) (Day) (Year)

7 AGE

\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or 1 min.?

If LESS than

1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Towson, Md.

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

Margaret Johnson

13 BIRTHPLACE OF MOTHER

(State or Country)

Towson, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Johnson

(Address)

Towson, Md.

15

Filed Aug 25, 1930W. R. Butler  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 25, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 \_\_\_\_ to \_\_\_\_ 192 \_\_\_\_

that I last saw him alive on \_\_\_\_ 192 \_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_ in.

The CAUSE OF DEATH \* was as follows:

Filled by stab wound in neck  
Wound thro severed.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

W. R. Butler (Coroner)192 \_\_\_\_ (Address) Towson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pasant RestAug 26, 1930

20 UNDERTAKER

Byron Wright

ADDRESS

215 W. Elderly St.

If more blanks are needed, address State Registrar, 17 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

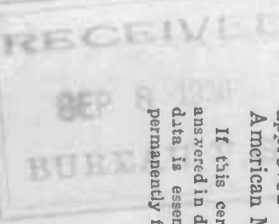
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

05279

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Spencer Point, Md (No. 88)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles A. Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE Widowed  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH April 16, 1867  
(Month) (Day) (Year)

7 AGE 63 yrs. 4 mos. 16 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

OCCUPATION  
(a) Trade, profession or particular kind of work Night Watchman  
(b) General nature of industry, business, or establishment in which employed (or employer) Service Stores Corp

9 BIRTHPLACE (State or country) Baltimore, Maryland

10 NAME OF FATHER Aaron Jones

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Ford

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1

(Address) \_\_\_\_\_

15 Filed May 12 19230 G. McCormick Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from his cause of death and that I last saw him live on 4:00 P.m.  
The CAUSE OF DEATH \* was as follows:

acute Myocarditis

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Dr. M. W. McHugh M. D.  
May 9, 1930 (Address) Spencer Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Asbury

DATE OF BURIAL

20 UNDERTAKER W. L. Chase son

ADDRESS

1400 Mosher

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

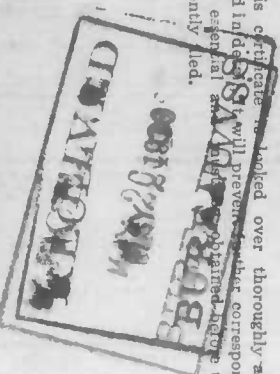
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dry laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent clerical correspondence. All the data is essential and should be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Harrois Point, Md. Lodge Farm Rd. St. 803 2nd Street

12202 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Claude June Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Mar. 12 1929  
(Month) (Day) (Year)

7 AGE 1 yrs. 6 mos. 28 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Va

10 NAME OF FATHER Joe. Jones

11 BIRTHPLACE OF FATHER (State or country) Calif.

12 MAIDEN NAME OF MOTHER Mary Field

13 BIRTHPLACE OF MOTHER (State or Country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe. Jones  
(Address) Lodge Farm Rd.

15 Filed Oct 16 1930 McComica, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 15 1930 to Oct 15, 1930  
that I last saw him alive on Oct 15, 1930

and that death occurred on the date stated above, at 9 P. m.  
The CAUSE OF DEATH \* was as follows:

Laryngeal Diphtheria

(Duration) yrs. mos. 2 ds.

Contributory Secondary None

(Duration) yrs. mos. ds.

(Signed) Dawson L. Harbor M. D.  
Oct 16 1930 (Address) Harrois Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Ashley Cemetery DATE OF BURIAL Oct 16, 1930

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Ashland St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, Tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 6 1930

MARGIN RESERVED FOR BINDING

WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

14695

# STATE OF MARYLAND CERTIFICATE OF DEATH

<sup>1</sup> PLACE OF DEATH  
County Balto.

(129)

Registration Dist. No. 4.2

Village or City Halcthorpe No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Elsie May Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♀ 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
(Write the word)

6 DATE OF BIRTH April 22, 1879  
(Month) (Day) (Year)

7 AGE 51 yrs. 7 mos. 19 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Philip M. Darsch

11 BIRTHPLACE OF FATHER (State or country) Balto City

12 MAIDEN NAME OF MOTHER Francis Dolphin

13 BIRTHPLACE OF MOTHER (State or country) Balto City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mavis Jones  
(Address) Halcthorpe, Md.

15 Filed Dec 10, 1930 Chas. H. Kieffer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from Oct 7, 1927 to Dec 10, 1930, that I last saw her alive on Dec 5, 1930

and that death occurred on the date stated above, at 5:30 A.M.  
The CAUSE OF DEATH \* was as follows:

apoplexy

Contributory (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Secondary Chronic Parenchymatous Nephritis  
Rheumatism (Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. S. Farson M. D.  
Dec 10, 1930 (Address) Halcthorpe, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL Dec 12, 1930

20 UNDERTAKER Jo. B. Cook ADDRESS 1003 W. Balto.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer. Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary, may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sorenia, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 3 1931

BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Catonsville(No. Rev. A. Opitz Home for Invalids St. Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thomas H. Jordan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>WIDOWED</u>
----------------------	---------------------------------	---

## 6 DATE OF BIRTH

April 12, 1840  
(Month) (Day) (Year)

## 7 AGE

90 yrs. 5 mos. 4 ds. or 1 day 1 hrs. 5 min. ?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) None

9 BIRTHPLACE  
(State or country)Virginia

## 10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or country)Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert E. Jordan(Address) 1700 Windemere Ave.

## 15

Filed 9/18 1930Registrar Adopty

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

September 16, 1930  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

July 17, 1930, to Sept. 16, 1930that I last saw him alive on Sept. 16, 1930and that death occurred on the date stated above, at 9 P. M.

## The CAUSE OF DEATH was as follows:

Myocardial Insufficiency(Duration) 6 yrs. 6 mos. 6 ds.Contributory  
Secondary(Duration) 6 yrs. 6 mos. 6 ds.(Signed) A. L. Wilkinson M. D.Sept. 17, 1930 A. L. Wilkinson  
(Address) 5110 Bel Air Rd., Balt.

\*State the Disease Causing Death, or, in deaths from Md. Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 17 yrs. 17 mos. 17 da. In the State, 17 yrs. 17 mos. 17 da.

Where was disease contracted, if not at place of death?

Former or usual residence 1700 Windemere Ave., Balt., Md.

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chicago Ill. Sept. 18, 1930

20 UNDERTAKER ADDRESS

Frank Cassam 7401 Belair Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Printer*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 4 1900  
BUREAU

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1 PLACE OF DEATH

County

Balto.

06010

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City

Hoods near north Pt. &amp; Canton P.R.

(No.)

Colgate

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Fred. Joska

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

married

6 DATE OF BIRTH

Aug. 10

1882

(Month)

(Day)

(Year)

7 AGE

48

yrs.

9

mos.

8

ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry business, or establishment in which employed or (employer)

Pressor

9 BIRTHPLACE

(State or country)

Czechoslovakia

10 NAME OF FATHER

Frank Joska

11 BIRTHPLACE OF FATHER

(State or country)

Czechoslovakia

12 MAIDEN NAME OF MOTHER

Frances Bockowsky

13 BIRTHPLACE OF MOTHER

(State or Country)

Czechoslovakia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frances Neboky

(Address)

801 N. Belwood Ave.

15

Filed

me 9

1920

John G. Connelley

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

About May 18 1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920 to

1920

that I last saw him alive on

1920

and that death occurred on the date stated above, at

m.

The CAUSE OF DEATH \* was as follows:

Suicide by Hanging

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Geo. W. Carson

June 8

1920 (Address)

Colgate Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the

State

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Texas Md.

June 9, 1920

20 UNDERTAKER

ADDRESS

John G. Connelley

Cress

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

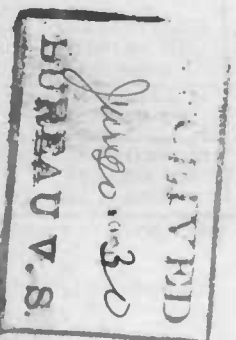
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchiopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchiopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u>		05280 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sparrows Point</u> (No. <u>705</u> )		Registration Dist. No. <u>HH</u>	
2 FULL NAME <u>still born infant Judy</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>	
8 DATE OF BIRTH <u>May 2<sup>d</sup></u> , 19 <u>30</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>May 2<sup>d</sup></u> , 19 <u>30</u> (Month) (Day) (Year)	
7 AGE ____ yrs. ____ mos. ____ ds. or ____ min.?		17 I HEREBY CERTIFY, That I attended the deceased from ____ 192____ to ____ 192____ that I last saw him alive on ____ 192____ and that death occurred on the date stated above, at <u>8:30</u> a.m. The CAUSE OF DEATH * was as follows: <u>still born</u> <u>7 mo</u> (Duration) ____ yrs. ____ mos. ____ ds.	
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)		Contributory Secondary (Signed) <u>G. C. McCormick</u> M. D. <u>May 3, 1930</u> (Address) <u>Sparrows Point</u>	
9 BIRTHPLACE (State or country) <u>MD</u>		*State the 1st cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
10 NAME OF FATHER <u>Frank C. Judy</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____	
11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>		19 PLACE OF BURIAL OR REMOVAL <u>Sent to Johns Hopkins</u>	
12 MAIDEN NAME OF MOTHER <u>Flornice L. Jorgensen</u>		DATE OF BURIAL ____, 19____	
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ill</u>		20 UNDERTAKER <u>Anatomical Laboratory</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Flornice L. Judy</u> (Address) <u>Sparrows Point</u>			
15 Filed <u>May 3, 1930</u> <u>G. C. McCormick</u> Registrar			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			8 08974 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Rossville</u> (No. _____, St.; _____ Ward)			Registration Dist. No. <u>44</u>		
2 FULL NAME <u>Kahler</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>M.</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>W</u>	16 DATE OF DEATH <u>Aug 2</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Aug 2</u> , 19 <u>30</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,		
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?			that I last saw h. _____ alive on _____, 191____,		
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry business, or establishment in which employed (or employer) _____			and that death occurred on the date stated above, at _____ m.		
9 BIRTHPLACE (State or country) <u>md</u>			The CAUSE OF DEATH * was as follows: <u>3 Mos. Miscarriage</u> (Duration) _____ yrs. _____ mos. _____ ds.		
10 NAME OF FATHER <u>Wm W. Kahler</u>			Contributory <u>Unknown</u> Secondary _____		
11 BIRTHPLACE OF FATHER (State or country) <u>md</u>			(Signed) <u>Frank A. Seantz</u> M. D. <u>Aug 2</u> , 19 <u>30</u> (Address) <u>3244 Eastern Ave</u>		
12 MAIDEN NAME OF MOTHER <u>Margaret Wienecke</u>			State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Kahler</u> (Address) <u>Rossville</u>					
15 Filed _____, 191 <u>3</u> <u>John J. Connelley</u> REGISTRAR					
19 PLACE OF BURIAL OR REMOVAL			DATE OF BURIAL _____, 191____		
20 UNDERTAKER			ADDRESS _____		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Tailor, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. If or persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Example: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis*.

8/23/30

44

help

*gas, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetania," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Balto.

02105

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Essex (No. Eastern Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Kalb

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
------------------------	---------------------------------	---

6 DATE OF BIRTH

Feb. 21st, 1930  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Balto. Co.

10 NAME OF FATHER

Matthew Kalb

11 BIRTHPLACE OF FATHER

(State or country)

Balto.

12 MAIDEN NAME OF MOTHER

Frances Imstich

13 BIRTHPLACE OF MOTHER

(State or Country)

Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Matthew Kalb

(Address)

Essex Md.

15

Filed

20. 23

1930

John S. Connolly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 21, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
1922 to 1922,that I last saw him alive on 1922

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

StillbornContributory  
Secondary(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) James J. White M. D.20 23, 1922 (Address) Essex Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

John Hopkins Lab.

DATE OF BURIAL

2/23/30, 1930

20 UNDERTAKER

John S. Connolly

ADDRESS

Essex

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere) symptoms, "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City White Marsh

2 FULL NAME Thomas Frandlik

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE M 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Sept 10, 1862  
(Month) (Day) (Year)

7 AGE 68 yrs. 3 mos. 6 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Sailor  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Bohemia

10 NAME OF FATHER Thomas Frandlik

11 BIRTHPLACE OF FATHER (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Bohemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna J. Frandlik

(Address) 1014 Linden Ave

15 Filed Dec. 17, 1930 John J. Connelley  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 10, 1930 to Dec 16, 1930, that I last saw him alive on Dec 16, 1930

and that death occurred on the date stated above, at 10:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Secondary Chronic nephritis

(Signed) E. J. Villase at M. D.  
Dec 17, 1930 Address Prossville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cath. Hill DATE OF BURIAL Dec 20, 1930

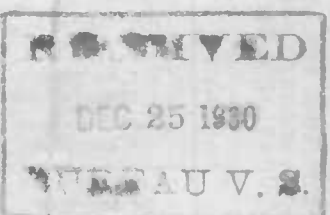
20 UNDERTAKER Frank Brackson ADDRESS 1906 Garland Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"



unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## HEALTH DEPARTMENT—CITY OF BALTIMORE

0187

## CERTIFICATE OF DEATH (90)

## 1—PLACE OF DEATH

REGISTERED NO. 38

CITY OF BALTIMORE: (No. Hillcrest Ave ST., WARD)

## 2—FULL NAME

Rudolph H Karow

## (a) RESIDENCE NO.

Hillcrest Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced, (write the word) Married
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5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Elizabeth Karow

6 DATE OF BIRTH (month, day, and year)

Sept 26 1860

7 AGE

Years

Months

Days

If LESS than  
1 day, .... hrs.  
or .... min.

69

3

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Laborer

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).  
(State or country)

Germany

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town).  
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town).  
(State or country)

Germany

14

Informant  
(Address)Mrs Elizabeth Karow  
2328 E Bay St

15

Filed

1/10

1930

G. M. Bacon

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 8 - 1930

17

HEREBY CERTIFY, That I attended deceased from

Jan 2, 1930, to Jan 8, 1930,

that I last saw him alive on Jan 8, 1930,

and that death occurred, on the date stated above, at 7:10 P. M.

The CAUSE OF DEATH\* was as follows:

Cardiac Metastasis  
Pulmonary embolism

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

Calculus of the gall bladder (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. J. Smith, M. D.

Jan 10 1930 (Address) 4706 Harper Road

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Oak Lawn Cem

Jan 11 1930

20 UNDERTAKER

John W. Allen

ADDRESS

2118 W. ...

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assn.]

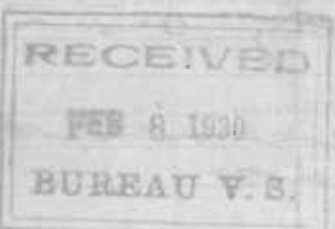
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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia," (merely symptomatic), "Arthropathy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN





WHEN ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
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1 PLACE OF DEATH  
County Baltimore

Village or City Fatherwick Md (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Kathleen M Kearns

08975

(129)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 37

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Dec 15 1901  
(Month) (Day) (Year)

7 AGE 28 yrs. 8 mos. 25 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Michael Barozzi

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Leonard

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Kearns

(Address) Fatherwick Md

15 Filed Aug 12 1930 - R R Bennett  
Deputy REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 10 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 27 1930 to Aug 10 1930,

that I last saw her alive on Aug 9 1930,

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Chronic Glomerular Nephritis  
with Hematuria

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) B. F. Busey M. D.  
Aug 10 1930 (Address) Zellus Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Joseph Cemetery Aug 12 1930

20 UNDERTAKER ADDRESS

Wm B. Smith Sparks Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the **second statement**. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal—septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 8 1930

BUREAU OF

HEALTH DEPARTMENT—~~CITY~~ OF BALTIMORE

08976

## CERTIFICATE OF DEATH. 74a

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 108 Sanford Ave ST. Catonsville WARD 74a)

## 2-FULL NAME

Albert C. Keen SrREGISTERED NO. 32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## (a) RESIDENCE No

108 Sanford Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

## 5 Single, Married, Widowed, or Divorced, (write the word)

## 5a If married, widowed, or divorced HUSBAND of (or) WIFE of

## 6 DATE OF BIRTH (month, day, and year)

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work

## (b) General nature of industry, business, or establishment in which employed (or employer)

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

## 14

Informant (Address)

## 15

Filed

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23-30

17

I HEREBY CERTIFY, That I attended deceased from

June, 1925, to 8-23-, 1930,that I last saw him alive on 8-23, 1930,and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
(Apoplexy)  
(Arterio Sclerosis)(duration) yrs. mos. 1/2 ds.

## CONTRIBUTORY (Secondary)

(duration) 5+ yrs. mos. ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? 5 yrs. operation(Signed) D. L. Lloyd Johnson, M. D.8/23 1930 (Address) Catonsville, Md.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL CREMATION OR RE-MOVAL

## DATE OF BURIAL

## 20 UNDERTAKER

## ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

463

PARENTS

Informant (Address)

Filed

Registrar

London Park8/26 1930Robert Brooks & SonCalhoun  
Hallam

# RECEIVED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name ori-

gin "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasias); *Measles*; *Whooping cough*, *chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Tanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

RECEIVED  
SEP 10 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto. Co.

14697 268 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Exeter (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Rose A. Keller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH March 12, 1901  
(Month) (Day) (Year)

7 AGE 50 yrs. 9 mos. 14 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER Charles Reynolds

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Connolly

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. William Keller  
(Address) 2404 Orleans St.

15 Filed Dec. 30 1920 John J. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 26, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 22, 1920 to Nov. 1, 1920, that I last saw her alive on Nov. 10, 1920

and that death occurred on the date stated above, at 206 p.m.  
The CAUSE OF DEATH \* was as follows:

Cancer of Stomach

Ascites

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Acute Myocarditis  
Secondary

(Signed) Geo. W. Carson M.D.  
Dec. 29, 1920 (Address) College Hill

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL New Cathedral DATE OF BURIAL 12/30/20

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto St.



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JAN 7 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL, peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		02640 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>		Registration Dist. No. <u>37</u>	
Village or City <u>Croftsville</u> (No. _____)		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Franklin Leslie Kelley</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Mar 12 1930</u> (Month) (Day) (Year)			
7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. <u>8</u> ds. or _____ min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>md</u>			
PARENTS	10 NAME OF FATHER <u>William Kelley</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>		
	12 MAIDEN NAME OF MOTHER <u>Alma Lucile Gussard</u>		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>md</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Wm Kelley</u> (Address) <u>Croftsville Md</u>			
15 Filed <u>Mar 24 1930</u> 3 (P. B. Burns) Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>March 20 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>March 12 1930</u> to <u>March 20 1930</u> that I last saw him alive on <u>March 19 1930</u> and that death occurred on the date stated above, at <u>5 P</u> m. The CAUSE OF DEATH * was as follows: <u>Cerebral Pith</u> (Duration) _____ yrs. _____ mos. <u>8</u> ds.			
Contributory Secondary _____ (Signed) <u>B. B. Burns</u> M. D. <u>Mar 24 1930</u> (Address) <u>Croftsville Md</u> *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury And (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>at home</u>		DATE OF BURIAL <u>March 27 1930</u>	
20 UNDERTAKER <u>John Burns &amp; Sons</u>		ADDRESS <u>Lourd Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 4 1930  
BUREAU

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH (43)

08977

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *Co. 718 Elmwood Rd.* ST. WARD)REGISTERED NO. *43*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

## (a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

*Male.*

## 4 COLOR OR RACE

*White*

## 5 Single, Married, Widowed, or Divorced, (write the word)

*Widowed*

## 6a If married, widowed, or divorced

HUSBAND OF

*(or) WIDOWED**Catherine Kelly*6 DATE OF BIRTH (month, day, and year) *Aug 26 1853*

## 7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*77**4**1*

## 8 OCCUPATION OF DECEASED

## (a) Trade, profession or particular kind of work.

*Retired*

## (b) General nature of industry, business, or establishment in which employed (or employer).

*Lawyer*

## (c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Texas*  
*Tex*

## 10 NAME OF FATHER

*William Kelly*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*

## 12 MAIDEN NAME OF MOTHER

*McNamee*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Ireland*

## 14

Informant  
(Address)*Mrs Thomas Barry*  
*718 Elmwood Rd*

## 15

Filed

*8/28 1930* *G. A. Fenty* M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

*Aug 27-1930*

## 17

I HEREBY CERTIFY, That I attended deceased from

*June 27, 1930, to Aug 27, 1930*that I last saw him alive on *Aug 27, 1930*and that death occurred, on the date stated above, at *245P* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma Mouth**Tongue + gums*(duration) yrs. *7* mos. *0* ds.

## CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

## 18 Where was disease contracted

if not at place of death? *no*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Microscopic*(Signed) *Thos Pa Stevens*, M. D.*8/28 1930* (Address) *28787 Harford*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*New Cathedral*

## DATE OF BURIAL

*Aug 30 1930*

## 20 UNDERTAKER

*Chas P Stevens*

## ADDRESS

*1505 E. Fort Ave*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As theia," "Anemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS





WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PARTICULARS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

Sheppard &amp; Enoch Pratt Hospital

Village or City Towson (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Kelly, Miss Josephine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>August 9, 1868</u> (Month) (Day) (Year)		
7 AGE <u>61</u> yrs. <u>11</u> mos. <u>16</u> ds. or min.?		

 8 OCCUPATION  
 (a) Trade, profession or particular kind of work nurse  
 (b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

 9 BIRTHPLACE  
 (State or country) Ireland Roscommon County

 10 NAME OF FATHER  
Luke Kelly

 11 BIRTHPLACE OF FATHER  
 (State or country) Ireland

 12 MAIDEN NAME OF MOTHER  
Jane McGuire

 13 BIRTHPLACE OF MOTHER  
 (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) \_\_\_\_\_

 15 Filed July 25, 1930 W. P. Bruch  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH  
July 25, 1930, 192  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from  
Aug. 31, 1926 to July 25, 1930  
 that I last saw her alive on July 25, 1930,  
 and that death occurred on the date stated above, at 11:56 a.m.

 The CAUSE OF DEATH \* was as follows:  
cardiorenal disease - involutional  
psychosis
unknown (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

 Contributory bronchopneumonia  
 Secondary \_\_\_\_\_

 (Signed) Ross W. C. Chapman M. D.  
July 25, 1930 (Address) Towson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death 3 yrs. 11 mos. 22 ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

 Former or usual residence 1647 East North Ave., Baltimore

19 PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

July 28, 1930

20 UNDERTAKER

Beta Friedfeld ADDRESS \_\_\_\_\_

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 7 1930  
BUREAU V 8

MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto</u>		05281 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Harrop Pt.</u> (No. <u>722</u> )		Registration Dist. No. <u>H.H.</u>	
2 FULL NAME <u>John J. Kelly</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>M</u> (Write the word)	
6 DATE OF BIRTH <u>Sept 17</u> , 18 <u>53</u> (Month) (Day) (Year)			
7 AGE <u>78</u> yrs. <u>8</u> mos. <u>29</u> ds. or _____ min.? If LESS than 1 day _____ hrs.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Ireland</u>			
PARENTS	10 NAME OF FATHER <u>John Kelly</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>		
	12 MAIDEN NAME OF MOTHER <u>Grace Flaherty</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ireland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Delia A. Kelly</u> (Address) <u>722 E. St.</u>			
15 Filed <u>May 17<sup>th</sup></u> 192 <u>3</u>		Registrar <u>J. A. Moran</u>	
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 16</u> , 192 <u>3</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 5<sup>th</sup></u> 192 <u>3</u> to <u>May 16<sup>th</sup></u> 192 <u>3</u> that I last saw him alive on <u>May 16</u> , 192 <u>3</u> and that death occurred on the date stated above, at <u>11 A. m.</u> The CAUSE OF DEATH * was as follows: <u>Cerebral Congestion</u> (Duration) _____ yrs. _____ mos. <u>10</u> ds. Contributory <u>Arterio Sclerosis</u> Secondary _____ (Duration) <u>3</u> yrs. _____ mos. _____ ds. (Signed) <u>G. H. McCormick</u> M. D. <u>May 17</u> 192 <u>3</u> (Address) <u>Sparks Point</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>New Catholic Calvary</u>		DATE OF BURIAL <u>May 19</u> , 19 <u>30</u>	
20 UNDERTAKER <u>J. A. Moran</u>		ADDRESS <u>3000 E. Balto. H.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

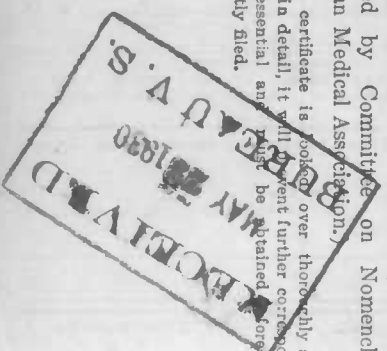
**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*;

(a) *Foreman*, (b) *Automobile factory*. The material world on may form part of the second statement. Never return "Laboree," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and may be obtained from the certificate is permanently filed.



WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Cockeysville P.O. No. 4

2 FULL NAME not named

08978  
8  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 37

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Still Born  
(Write the word)

6 DATE OF BIRTH Aug 15<sup>th</sup> 1920  
(Month) (Day) (Year)

7 AGE Still Born (miscanap) If LESS than 1 day... hrs. yrs. mos. 8 1/2 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balt Co Md

10 NAME OF FATHER Samuel G Kelley

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER R. H. Smithson

13 BIRTHPLACE OF MOTHER (State or country) Harford Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel G Kelley

(Address) Cockeysville P.O. Md

15 Filed Aug 15<sup>th</sup> 1920 J. Drach M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 15<sup>th</sup> 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 15<sup>th</sup> 1920 to Aug 15<sup>th</sup> 1920.

that I last saw him alive on Still Born, 1920.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Diseased Placenta

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) John H. Drach M. D.  
Aug 15<sup>th</sup> 1920 (Address) Cockeysville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL in Garden at Home DATE OF BURIAL Aug 15<sup>th</sup> 1920

20 UNDERTAKER Samuel G Kelley (Father) ADDRESS Cockeysville Md



Inf. added from birth certificate in file Aug 10/30.  
28. 9/17/30

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet fever* (never report "Scarlet Pneumonia"); *Whooping cough* (never report "Whooping Cough Pneumonia"); *Branchiopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-atie), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 6 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Balto.

13565 233

(101-a)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City North Point (No. Fairview Ave. Eastern Ave. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Barbara Kellner

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH Oct. 20<sup>th</sup>, 1886  
(Month) (Day) (Year)7 AGE 94 yrs. 25 mos. 25 ds. or LESS than 1 day hrs. min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Germany10 NAME OF FATHER Voetger11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margt. Cumberland(Address) Fairview Eastern Ave.15 Filed Nov 16 1930 J. V. Cornelly Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 14<sup>th</sup>, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov. 12 1930 to Nov. 14 1930.that I last saw her alive on Nov. 14 1930.and that death occurred on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH \* was as follows:

Lobar PneumoniaContributory  
Secondary(Duration) 2 yrs. 4 mos. 25 ds.  
(Signed) M. A. Gaeon M. D.  
192 (Address) 1785 N. Kenton St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, institutions, Transients &amp; Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cemetery Nov. 17, 1930

20 UNDERTAKER

ADDRESS

Lilly & Geiler Inc. 443 S. Wolfe St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

0188 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Dundalk (No. 259 Colgate ave St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edward Francis Kelly

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept. 14, 1887  
(Month) (Day) (Year)

7 AGE 42 yrs. 4 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Merchant  
(b) General nature of industry, business, or establishment in which employed or (employer) Merchandise

9 BIRTHPLACE (State or country) Baltimore Co. Md.

10 NAME OF FATHER Edward Francis Kelly

11 BIRTHPLACE OF FATHER (State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Livingston

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Kelly  
(Address) Dundalk Md.

15 Filed 1/27/30 Dundalk  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 4, 1929 to Jan 27, 1930, that I last saw him alive on Jan 10, 1930,

and that death occurred on the date stated above, at 10-30 A. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

(Duration) 6 yrs. — mos. — ds.

Contributory Secondary none

(Duration) — yrs. — mos. — ds.

(Signed) Art Riser M. D.  
Jan 27, 1930 (Address) Dundalk, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL St. Marys Cem. DATE OF BURIAL Jan 30 1930

20 UNDERTAKER Robt J. Gorman ADDRESS 4407 Broadway

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

FEB 8 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as *Asthemia, "Anaemia"* (merely symptomatic), *"Atrophy"* "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hranton," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, *Gas fracture of skull, and consequences (e. g., sepsis, tetanus)* may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

12203 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 13

Village or City Glyndon (No. MD)

St. MD Ward MD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William H Kelley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH July 14, 1868  
(Month) (Day) (Year)

7 AGE 62 yrs. 2 mos. 30 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Superintendent  
(b) General nature of industry, business, or establishment in which employed or (employer) United Railways

9 BIRTHPLACE (State or country) Baltimore MD

10 NAME OF FATHER William H Kelley

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane E. Bowers

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. H E Kelley

(Address) Glyndon MD

15 Filed Oct 15 1930 10200 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1930 to Oct 13, 1930

that I last saw him alive on Oct 12, 1930

and that death occurred on the date stated above, at 6:30 A.M.  
The CAUSE OF DEATH \* was as follows:

Inanition

(Duration) 1 yrs. 1 mos. 1 ds.

Contributory Acute Sarcina of R Ribs  
Secondary and Cirrhosis of Liver  
(Duration) 7 yrs. 8 mos. 1 ds.

(Signed) J Rown M. D.  
Oct 14, 1930 (Address) Glyndon MD

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ashbury M E Cemetery Oct 15, 1930

20 UNDERTAKER Reedman ADDRESS

J F Ehrlich Reedman

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 5 1930

BUREAU OF

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

01393

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 31Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thomas Kelly

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE, single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

March 14, 1883  
(Month) (Day) (Year)

7 AGE

46 yrs. 11 mos. 4 ds. or 1 day 1 hrs. 1 min.?  
If LESS than

8 OCCUPATION

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Baltimore, Md

10 NAME OF FATHER

Thomas Kelly

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Alice Donnelly

13 BIRTHPLACE OF MOTHER

(State or Country)

Baltimore, Md14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records--Personal History

(Informant)

Eudowood Sanatorium, Towson, Md.  
(Address)

15

Filed Feb 18 1930Dr. P. Kelly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the decedent from

May 16, 1929 to February 18, 1930that I last saw him alive on February 18, 1930and that death occurred on the date stated above at 8:40 A.M.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis(Duration) 8 yrs. 11 mos. 4 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. C. Bridges M. D.1930 (Address) Towson, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 9 yrs. 11 mos. 4 ds. In the ap State 9 yrs. 11 mos. 4 ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church Feb 21, 1930

20 UNDERTAKER

ADDRESS

Lilly & Sons One 2030 W. 15

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

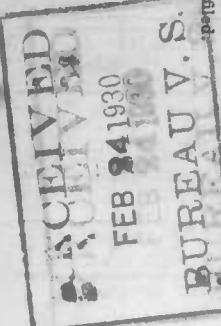
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*Baltimore*

13566

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *38*

Village or City

*Towson*

(No.)

*11 E. Joppa Road*

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Sarah F. Kelso*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Widow*

6 DATE OF BIRTH

*Jan. 26, 1851*  
(Month) (Day) (Year)

7 AGE

*79 yrs. 9 mos. 5 ds.*  
If LESS than 1 day... hrs. or... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*At Home*

(b) General nature of industry, business, or establishment in which employed or employer

9 BIRTHPLACE

(State or country)

*Baltimore, Co. Md.*

10 NAME OF FATHER

*A. Truener*

11 BIRTHPLACE OF FATHER

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Susanna Turnbull*

13 BIRTHPLACE OF MOTHER

(State or country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Miss Nellie Kelso*

(Address)

*13 E. Joppa Road*

15

Filed *Nov 3**1930**John P. Butler*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Nov 1, 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Oct 1, 1930* to *Oct 31, 1930*.that I last saw him alive on *Oct 31, 1930*.and that death occurred on the date stated above, at *9:50 P.M.*

The CAUSE OF DEATH \* was as follows:

*Myocardial Decompensation*(Duration) *6* yrs. *6* mos. *6* ds.

Contributory Secondary

*Arteriosclerosis*(Duration) *12* yrs.

(Signed)

*John P. Butler* M. D.*Nov 2, 1930* (Address) *Towson, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Prospect Hill (Towson) Nov. 4, 1930.*

20 UNDERTAKER

ADDRESS

*Horace F. Burgee 3631 Falls Road.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

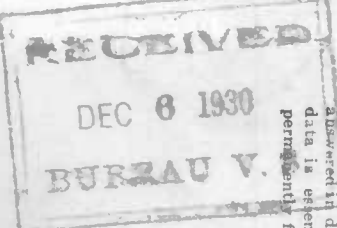
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationery fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return *Laborer, "Foreman," "Manager," "Dealt."* etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Assthonia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. . . . . the data is essential and must be obtained before the certificate is permanently filed.



WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Baltimore.

05282 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Batonsville (No. 17 Eusting Ave. St.: \_\_\_\_\_ Ward: \_\_\_\_\_)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Charles Milton Kemp

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Feb. 11, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. 3 mos. 7 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work retired Salesman  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Prothurg Md.

10 NAME OF FATHER Leury Kemp

11 BIRTHPLACE OF FATHER (State or country) Fredrick Co.

12 MAIDEN NAME OF MOTHER Amanda Trail

13 BIRTHPLACE OF MOTHER (State or Country) Fredrick Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. J. Bonn Kemp

(Address) 3806 Gleggyle Ave.

15 Filed May 19 1930 C. L. Muffield

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 10, 1930 to May 18, 1930, that I last saw him alive on May 18, 1930

and that death occurred on the date stated above, at 9 P m.

The CAUSE OF DEATH \* was as follows:

Hypostatic Pneumonia  
Arterio Sclerosis  
Cardiac Dilatation

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.

Contributory Secondary

Arterio Sclerosis

(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) James S. Axtel M. D.

5-19 1930 (Address) 412 Park Heights

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

May 21, 1930

20 UNDERTAKER

ADDRESS

C. Vernon Lemon

461 Park Heights Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

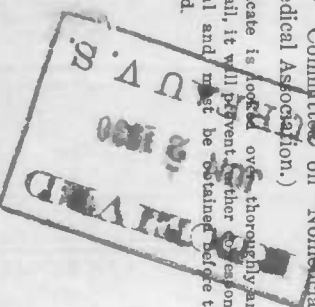
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, teratomum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is filed or otherwise thoroughly and accurately answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

14698

(74a)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 33

Village or City

Freeland (No. \_\_\_\_\_)

St.:

Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Edith P. Kemp

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)widowed

6 DATE OF BIRTH

Nov.241859

(Month)

(Day)

(Year)

7 AGE

71 yrs.— mos.24 ds.IF LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Housekeeper

9 BIRTHPLACE

(State or country)

Iowa

10 NAME OF FATHER

Oscar A. Thornton

11 BIRTHPLACE OF FATHER

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Carrie E. Billings

13 BIRTHPLACE OF MOTHER

(State or country)

Connecticut

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry T. Kemp

(Address)

Freeland, Md.

15

Filed

Dec 181930Edith P. Kemp  
Regist. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 181930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 111930to Dec 181930that I last saw him alive on Dec 17, 1930,

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

7 ds.Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Samuel H. Hackett

M. D.

Dec 181930

(Address)

Shawbury, Pa.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Lowell Park

DATE OF BURIAL

Dec 20, 1930

20 UNDERTAKER

Wm. J. Tuckney & Sons

ADDRESS

North, Pa.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 7 1901  
BUREAU V. B.



MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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05283

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 01

92

1 PLACE OF DEATH  
County Baltimore

Village or City Pikesville (No. 213 Church Lane) (Ward 1) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Bessie M. Kennedy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH July 12, 1877  
(Month) (Day) (Year)

7 AGE 52 yrs. 10 mos. 4 ds. or 1 day 1 hrs. 52 min. If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER James Kennedy

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Olga Conway

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Bliss Kennedy  
(Address) 213 Church Lane

15 Filed May 16 1930 E. E. Nichols  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 15, 1930 to May 16, 1930  
that I last saw her alive on May 16, 1930  
and that death occurred on the date stated above, at 2:50 A.M.  
The CAUSE OF DEATH \* was as follows:  
Embolism coronary artery  
(Duration) few minutes yrs. mos. ds.

Contributory  
Secondary

(Signed) E. E. Nichols M. D.  
May 16 1930 (Address) Pikesville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death 1 yrs. 10 mos. 4 ds. In the State 1 yrs. 10 mos. 4 ds.

Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Charles Cemetery DATE OF BURIAL May 19, 1930

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 118 N. M. Carey

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 2 1930  
BUREAU V. S.

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1 PLACE OF DEATH  
County Balto

Village or City Freeland Md (No. 49)

2 FULL NAME John Kerl

03994 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 35

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Dec 21 1865  
(Month) (Day) (Year)

7 AGE 64 yrs. 3 mos. 18 ds. or min.?  
IF LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Telegraph Operator  
(b) General nature of industry, business, or establishment in which employed or (employer) P. R. R.

9 BIRTHPLACE (State or country) Freeland Md

10 NAME OF FATHER Andrew Kerl

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Kraft

13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sybil W. Kerl

(Address) Freeland Md

15 Filed April 10 1930 Samuel S. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 9 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1 1929 to Apr 9 1930, that I last saw him alive on Apr 9 1930

and that death occurred on the date stated above, at 5:40 a.m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of Prostate

Contributory (Duration) 2 yrs. 1 mos. 1 ds.

Secondary Myeloid Leukemia

(Signed) W. C. Boyer M. D.

Apr 10 1930 (Address) Freeland Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Shrubsburg DATE OF BURIAL Apr 11 1930

20 UNDERTAKER Hartenstein & Son ADDRESS Freeland Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>42</u>		
Village or City <u>Lansdowne</u> (No. _____)			St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Lora E. C. Fessler</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Dec. 14, 1880</u> (Month) (Day) (Year)					
7 AGE <u>49</u> yrs. <u>3</u> mos. <u>15</u> ds. or <u>LESS</u> than 1 day _____ hrs. _____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Lansdowne Md.</u>					
PARENTS	10 NAME OF FATHER <u>Christian Grandau</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Christina Heering</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>					16 DATE OF DEATH <u>Nov. 29, 1930</u> (Month) (Day) (Year)
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George Fessler</u> (Address) <u>Lansdowne</u>					
15 Filed <u>Nov 31 1930</u> <u>J. M. Lipp</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov. 9, 1930</u> to <u>Nov. 29, 1930</u> that I last saw him alive on <u>Nov. 29, 1930</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Chronic nephritis - duration, six months</u> <u>and 40.</u> (Duration) _____ yrs. _____ mos. <u>1</u> ds.					
Contributory (Duration) _____ yrs. _____ mos. _____ ds. <u>Bright</u> (Signed) <u>St. Louis</u> M. D. <u>3/31-1930</u> (Address) <u>1341 1/2 Ave</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. <u>1340 1/2 Ave</u>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Calvary Cemetery</u>			DATE OF BURIAL <u>April 1, 1930</u>		
20 UNDERTAKER <u>Harold J. Flynn</u>			ADDRESS <u>1400 Light St.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Heart failure," "Old Age," "Shock," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 8 1930  
BUREAU V. S.

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH.

County Baltimore

01394

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 23Village or City Owings Mills (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Henry Kessler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH May 19, 1918  
(Month) (Day) (Year)7 AGE 11 yrs. 8 mos. 20 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate  
(b) General nature of industry, business, or establishment in which employed or (employer) Rosewood State Training School, Owings Mills, Md.

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Kessler  
11 BIRTHPLACE OF FATHER (State or country) Pennsylvania  
12 MAIDEN NAME OF MOTHER Myrtle Sprinkle  
13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Institutional Records  
(Address) Rosewood State Training School, Owings Mills, Md.

15 Filed Feb 9, 1930 H. M. Slader  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 9, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Feb 6, 1930, to Feb 9, 1930, that I last saw him alive on Feb 8, 1930,and that death occurred on the date stated above, at 4:30 a.m.  
The CAUSE OF DEATH \* was as follows:Status Epilepticus(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) George C. Medaury M. D.  
Feb 9, 1930 (Address) Owings Mills, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. 2 mos. 17 ds. In the State 11 yrs. 8 mos. 20 ds.Where was disease contracted, if not at place of death? CongenitalFormer or usual residence Baltimore, Md.19 PLACE OF BURIAL OR REMOVAL St. Marys Hampden DATE OF BURIAL Feb 11, 193020 UNDERTAKER Chenoweth & Son ADDRESS 3615 Chestnut

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 6 1930

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Jones Creek (No.       )

2 FULL NAME still born infant. (Ketchum)

03995 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH April 24<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE        yrs.        mos.        ds. or        min.? If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Jones Creek Md.

10 NAME OF FATHER David Ketchum

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Hazel L. Miller

13 BIRTHPLACE OF MOTHER (State or Country) Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Ketchum  
(Address) Jones Creek

15 Filed Apr 25 1930 G. C. McConner Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw h.        alive on       , 192

and that death occurred on the date stated above, at        m.

The CAUSE OF DEATH \* was as follows:

still born infant

Contributory Secondary (Duration)        yrs.        mos.        ds.  
Premature birth

(Signed) G. C. McConner M. D.  
Apr 25 1930 (Address) Spencer Bldg

\*State the 1 is ase Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Mt Carmel DATE OF BURIAL Apr 25, 1930

20 UNDERTAKER James P. Kalkowski ADDRESS Balto

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 5 1930  
BUREAU OF VITAL STATISTICS





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Railroad wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH,  
County Baltimore

Village or City Catonsville (No. Opitz Home St.; Ward)

2 FULL NAME Mary Elizabeth Kibler

05284  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH September 14, 1865  
(Month) (Day) (Year)

7 AGE 64 yrs. 7 mos. 24 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housekeeper  
(b) General nature of industry, business, or establishment in which employed (or employer) Homans Livery

9 BIRTHPLACE (State or country) Cockeysville Md

10 NAME OF FATHER Mr. Kibler

11 BIRTHPLACE OF FATHER (State or country) Cockeysville Md

12 MAIDEN NAME OF MOTHER Mary Ann Kibler

13 BIRTHPLACE OF MOTHER (State or country) Cockeysville Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Malv. Bartlett  
(Address) 1836 S. Charles St

15 Filed 5-8-30, 1930 Dr. Chas. Matfield

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930 to May 8, 1930, that I last saw h. e. r. alive on May 8, 1930

and that death occurred on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH\* was as follows:

Initial Regurgitation

Contributory Secondary Exhaustion  
(Duration) yrs. 1 mos. 2 ds.

(Signed) R. H. Campbell, M. D.  
May 8, 1930 (Address) 1644 Hanover St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 1 ds. In the 64 yrs. 7 mos. 24 ds.

Where was disease contracted, unknown.

If not at place of death? unknown.

Former or usual residence 1836-S-Charles-St.

19 PLACE OF BURIAL OR REMOVAL Baltimore Md DATE OF BURIAL May-10, 1930

20 UNDERTAKER Heumel Monro ADDRESS Baltimore Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by curbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY as given. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Baltimore

65285 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville (No. Spring Grove Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Stephen Joseph Kilduff

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH April 11, 1868  
(Month) (Day) (Year)

7 AGE 62 yrs. 1 mos. 15 ds. If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Linotype Operator  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ma

10 NAME OF FATHER Arthur Kilduff

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Kilduff  
(Address) 1322 Ainslie St.

15 Filed 3/29 1930 St. Andrew Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 23, 1929 to May 27, 1930  
that I last saw him alive on May 20, 1930

and that death occurred on the date stated above, at 7:30 A. M.  
The CAUSE OF DEATH \* was as follows:

Mitral Insufficiency  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Atherosclerosis  
Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Bar. E. G. Garrett M. D.  
May 27, 1930 (Address) Catonsville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 3 ds. In the State 69 yrs. 1 mos. 15 ds.

Where was disease contracted at place of death  
it not at place of death?

Former or usual residence Balto. Md.

19 PLACE OF BURIAL OR REMOVAL Robert Catholic Bur. DATE OF BURIAL 30, 1930

20 UNDERTAKER Wm. Shidfield ADDRESS 914 Summit Ave.

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balt., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Conductor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Fireman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 8 1920  
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

Village or City Owings Mills (No. \_\_\_\_\_)

<sup>2</sup> FULL NAME Adolph Henry Kindberg

02642 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 2

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 11<sup>th</sup>, 1913  
(Month) (Day) (Year)

7 AGE 16 yrs. 5 mos. 29 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate  
(b) General nature of industry, business, or establishment in which employed or (employer) Preserved State Train School Owings Mills, Md.

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Charles Kindberg

11 BIRTHPLACE OF FATHER (State or country) Denmark

12 MAIDEN NAME OF MOTHER Katie Jahn

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Institutional Records  
(Address) Preserved State Training School, Owings Mills, Md.

15 Filed Feb 10 1930 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 5, 1930, to Mar 10, 1930, that I last saw him alive on Mar 10, 1930,

and that death occurred on the date stated above, at 10:45 a.m.  
The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis  
(Duration) Unknown

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) George C. Medaery M. D.  
Mar 10 1930 (Address) Owings Mills, Md.

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 12 yrs. 4 mos. 14 ds. In the 16 yrs. 5 mos. 29 ds. State

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Baltimore, Md.

19 PLACE OF BURIAL OR REMOVAL Balto. Cem DATE OF BURIAL Mar 13 1930

20 UNDERTAKER Philip Herwig ADDRESS 2816 Orleans St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

*Transcribed Book 10-1830*  
*Atm. O. L. A. W.*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 7 1900

BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County \_\_\_\_\_

198

66482 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Hamadville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Francis Valentini King

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
------------------------	-----------------------------------	---

6 DATE OF BIRTH  (Month) _____ (Day) _____ (Year) _____
---

7 AGE <u>about 35</u> yrs. _____ mos. _____ ds. _____	If LESS than 1 day _____ hrs. _____ or _____ min. _____
--	---

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)
--

9 BIRTHPLACE (State or country)
------------------------------------

10 NAME OF FATHER
-------------------

11 BIRTHPLACE OF FATHER (State or country)
---

12 MAIDEN NAME OF MOTHER
--------------------------

13 BIRTHPLACE OF MOTHER (State or Country)
---

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Coats(Address) Hamadville Md15 Filed June 11, 1930 W. E. E. Michael  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 9, 1930  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_\_\_ to \_\_\_\_\_ 192\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 192\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Fractured skull and  
slipped left jugular vein and  
right jugular and right carotid  
artery. Homicide. Throat cut by a sharp  
instrument, and skull  
fractured by a blunt instrument in the hands of  
Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Amthor J. Cooper M. D.June 11, 1930 (Address) Pikesville Md

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Catharine June 12, 1930

20 UNDERTAKER ADDRESS

Frank H. Newell Pikesville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationery fremen, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (o) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (o) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E.haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Rendur wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 1 1924  
BUREAU V. S.



WRITE ANY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATH

02643

Registration Dist. No. 42Village or City Halathorpe (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret May Kirchaeffer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

Aug 22, 1846  
(Month) (Day) (Year)

7 AGE

83 yrs. 6 mos. 15 ds. or min. ?  
If LESS than 1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work.

Domestic

(b) General nature of industry, business, or establishment in which employed or (employer).

Sanitary

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Jacob Schaub

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth F. ?

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Jacob Kirchaeffer

(Address)

Halathorpe Md

15

Filed

Mch 9, 1930J. Kirchaeffer

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mch 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Mch 5, 1930, to Mch 9, 1930that I last saw her alive on Mch 9, 1930and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH was as follows:

Bronch pneumonia  
Myocardial infarction(Duration) yrs. mos. 5 da.

Contributory

Secondary

Several Arterio  
Sclerosis, Senility  
(Duration) yrs. mos. 4 da.

(Signed)

W. B. Brumbaugh M. D.  
Mch 9, 1930 (Address) Elkridge Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Ave 3/12, 1930

20 UNDERTAKER

ADDRESS

Fredrick Lee Elkridge Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

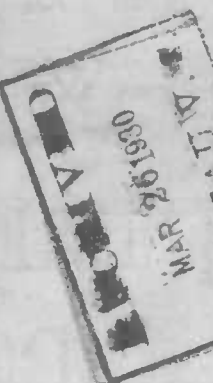
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Printer*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. (are should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Attainment of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is *essential* and must be obtained before the certificate is *completeness* filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Hebbville (No. Windsor Mill Road St. Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 31

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charlotte Kirk

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH March 3, 1851  
(Month) (Day) (Year)

7 AGE 78 yrs. 10 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9 BIRTHPLACE (State or country) Roslyn Baltimore County, Md.

10 NAME OF FATHER Valentine Smith

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Weikel

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. John Kirk(Address) Windsor Mill Road, Hebbville

15 Filed Jan 10 - 30 1930 M. N. Bueffer  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1929, to Jan 9, 1930  
that I last saw him alive on Jan 8, 1930

and that death occurred on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of liver  
secondary to gall bladder

(Duration) 6 yrs. 6 mos. 6 ds.

Contributory (Secondary)

(Duration) 6 yrs. 6 mos. 6 ds.(Signed) A. C. Smith, M. D.

Jan 10, 1930 (Address) 4309 Federal Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL Jan 11, 1930Mt. Olive, Roslyn

20 UNDERTAKER

ADDRESS

1003 West  
Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930  
BUREAU V. C.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Balto.*

01395

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*157 44*

Village or City

*Essex*

(No.)

*Mace + Hutchinson Aves*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Antionette B. Kirsch*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Married*

8 DATE OF BIRTH

*July**3**1874*

(Month)

(Day)

(Year)

7 AGE

*55**7*

mos.

*21*

ds.

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*At home*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Germany*

10 NAME OF FATHER

*Not known*

11 BIRTHPLACE OF FATHER

(State or country)

*Not known*

12 MAIDEN NAME OF MOTHER

*Not known*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Not known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Ottillie Blimline*

(Address)

*Essex*

15

Filed

*Feb. 26*

1920

*John J. Connelly*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Feb**24**1920*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*January 25*

1920

*to Feb. 24,**1920*that I last saw her alive on *dead on 2-24-* 1920and that death occurred on the date stated above, at *5:15a* m.

The CAUSE OF DEATH \* was as follows:

*Apoplexy*Contributory  
Secondary*Pulmonary oedema*

(Duration)

*Several hours*

ds.

(Signed)

*I. E. Bronushas*

M. D.

*2-24-30*

1920

(Address)

*3037 O'Donnell St*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Oaklawn Cemetery*

DATE OF BURIAL

*Feb 27**1920*

20 UNDERTAKER

*George W. Zickler*

ADDRESS

*1737 E. Eagan St*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 6 1900

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore  
North Point

Village or City Shinn's Point (No. 44)

2 FULL NAME Charles H. Kirschner

10850

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

St. R.F.D. #40 Ward 4 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 2, 1866  
(Month) (Day) (Year)

7 AGE 64 yrs. 4 mos. 11 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Louisville, Ky.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary E Kirschner  
(Address) North Point Md

15 Filed Sept 15 1930 by G. McNamee Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 13<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1, 1920 to Sept 13<sup>th</sup>, 1930, that I last saw him alive on Sept 13<sup>th</sup>, 1930,

and that death occurred on the date stated above, at 10:50 a.m. The CAUSE OF DEATH \* was as follows:

Carcinoma Stomach

(Duration) 3 yrs. 3 mos. 2 ds.  
Contributory Secondary Stomach

(Signed) Ismael G. Eldred M. D.  
9/13, 1930. (Address) Shinn's Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Parkwood DATE OF BURIAL Sept 16, 1930

20 UNDERTAKER John F. Denney ADDRESS 715 Light St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 6 1930  
BUREAU

CERTIFICATE OF DEATH 89COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICSFile No. 052861. PLACE OF DEATH  
County of Baltimore  
Township of Herrford  
or  
Borough of  
or  
City ofRegistration District No. 35

Primary Registration District No.

Registered No.

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

2. FULL NAME

Richard Klant

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married5a. If married, widowed, or divorced  
HUSBAND of Alice Klant  
(or) WIFE of6. DATE OF BIRTH (month, day, and year) Nov 9 - 18807. AGE Years Months Days IF LESS than 1 day, hrs. of min.  
50 2 16

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employerMachine Printer9. BIRTHPLACE (city or town) Germany  
(State or country)10. NAME OF FATHER Augustus Klant11. BIRTHPLACE OF FATHER (city or town) Germany  
(State or country)12. NAME OF MOTHER Pauline Jonge13. BIRTHPLACE OF MOTHER (city or town) Germany  
(State or country)14. Informant Alice Klant  
(Address) York Pa15. Filed 5/24 1930 Dr. B. B. B. B. B.

11-3184

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25 1930  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from, May 20<sup>th</sup> 1930, to Sudden Death, 1930, that I last saw him alive on May 20<sup>th</sup> 1930, and that death occurred, on the date stated above, at 1:30 a.m.  
The CAUSE OF DEATH\* was as follows:  
Angina PectorisCONTRIBUTORY (SECONDARY) (duration) commercial yrs. mos. ds.18. Where was disease contracted (duration) yrs. mos. ds.  
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Drach M.D.  
19 (Address) Cockeysville Md.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Chicago Ill. May 28 1930

20. UNDERTAKER ADDRESS

P. M. Schell White Hall Md.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

RECEIVED

JUN 7 1930

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

**Statement of cause of death.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of

the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *carcinoma, Sarcoma, etc.* of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), 29 ds; *Bronchopneumonia (secondary)*, 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicaemia" "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

Space for additional information by physician.



If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 4 1900

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07714

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 31Village or City Granite (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elsie E. Klein

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug 4, 1895  
(Month) (Day) (Year)

7 AGE 34 yrs. 11 mos. 7 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) N.C.

10 NAME OF FATHER Geo. H. Fisher

11 BIRTHPLACE OF FATHER (State or country) N.C.

12 MAIDEN NAME OF MOTHER Laura C. Miller

13 BIRTHPLACE OF MOTHER (State or Country) N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Klein(Address) Granite Md.15 Filed Aug 11 1930 H. J. Dwyer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1, 1929, to July 11, 1930, that I last saw her alive on July 11, 1930,

and that death occurred on the date stated above, at 109 m. The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis  
(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Harry J. Dwyer M. D.  
July 11 1930 (Address) Woodlawn

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Granite Pres. Cemetery July 13, 1930

20 UNDERTAKER ADDRESS

Neer Bow Sykesville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

01396

(74-2)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43

Village or City

Fullerton(No. 102)14000 Rock Road near Overton Ave.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

George B. Kline

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

Sept. 13, 1859  
(Month) (Day) (Year)

7 AGE

70 yrs. 4 mos. 26 ds.  
If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

Retired9 BIRTHPLACE  
(State or country)Maryland

10 NAME OF FATHER

Henry Kline11 BIRTHPLACE OF FATHER  
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Catherine Kramer13 BIRTHPLACE OF MOTHER  
(State or Country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fredmond Kline

(Address)

Fullerton Md 21038

15

Filed

2/11 1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 9, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Jan. 14, 1928 to FEB 9, 1930that I last saw him alive on FEB 8, 1930and that death occurred on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH \* was as follows:

Bulbar Paralysis  
Cerebral Hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
SecondaryArterio Sclerosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

Clay Smith

M. D.

Exp. 10, 1930 (Address) 4706 Harford Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Camp Chapel Cemetery Feb. 12, 1930

20 UNDERTAKER

ADDRESS

Frederick Lassahnton Fullerton



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 4 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Calvert

Village or City White Hall Md (No. 129)

03996 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 35

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME David Mangelhofer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH May 21, 1854  
(Month) (Day) (Year)

7 AGE 75 yrs. 10 mos. 27 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) Wheelwright

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward E. Mangelhofer

(Address) White Hall Md.

15 Filed April 18, 1930 M. Bortner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 11, 1930 to April 18, 1930

that I last saw him alive on April 17, 1930

and that death occurred on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis

(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Milner Bortner M. D.

April 18, 1930 (Address) White Hall Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emmanuel Cemetery April 21, 1930

20 UNDERTAKER ADDRESS

Lewis Heeman 32 S Broadway

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Balto.

Village or City Texas (No. \_\_\_\_\_)

2 FULL NAME John Knapp

13567 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 37

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb 22, 1855  
(Month) (Day) (Year)

7 AGE 75 yrs. 8 mos. 10 ds. (If LESS than 1 day, hrs. or min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed or (employer) Self

9 BIRTHPLACE (State or country) Balto., Co. Md.

10 NAME OF FATHER John Knapp.

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (State or Country) Li

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Selinda Knapp.

(Address) Texas Balto. Co. Md.

15 Filed Nov 7, 1930 B. B. Beump Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 31, 1930 to Nov 4, 1930, that I last saw him alive on Nov. 3, 1930

and that death occurred on the date stated above, at 10:04 A. M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia (Indef)

(Duration) 4 yrs. 4 mos. 4 ds.

Contributory Arteriosclerosis and Secondary

Diabetes mellitus (Duration) 10 yrs. 10 mos. 10 ds.  
(Signed) B. B. Beump Registrar  
Nov 5, 1930 (Address) Seeford Md

\*State the Disease Causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 4 mos. 4 ds. In the State 4 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Shepherd Cemetery DATE OF BURIAL Nov 7, 1930

20 UNDERTAKER George W. Ziebler ADDRESS 1737 E. Cogan

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia."); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU V. S.



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Baltimore*

Village or City

*Waverly P.D.* (No. \_\_\_\_\_)

2 FULL NAME

*not named (Annap)*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *34*

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

*Single*

6 DATE OF BIRTH

*Jan 26<sup>th</sup> 1930*  
(Month) (Day) (Year)

7 AGE

*Still Born*  
yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Md*

10 NAME OF FATHER

*John H. Knapp*

11 BIRTHPLACE OF FATHER

(State or country)

*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Mary Allison*

13 BIRTHPLACE OF MOTHER

(State or country)

*Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*James Annap*

(Address)

*Waverly P.D. Md*

15

Filed *Jan 28 1930* *C. E. Frothe M.D.* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 26<sup>th</sup> 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Jan 26<sup>th</sup> 1930* to *Jan 26<sup>th</sup> 1930*that I last saw him alive on *Dead* *1930*and that death occurred on the date stated above, at *4:30 p.m.*

The CAUSE OF DEATH \* was as follows:

*Still born (Hydrocephalic)  
Arched Instrumental delivery  
Child dead (in uterus)*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary

*Premature Birth 8<sup>th</sup> mos*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *John H. Drach* M.D.  
*Jan 26 1930* (Address) *Cockeysville Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Black Rock Church Cemetery Jan 28<sup>th</sup> 1930*

20 UNDERTAKER

ADDRESS

*James Annap (Grandfather) Waverly P.D. Md*

(Approved by U. S. Census and American Public Health Association.)

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cere brospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet pneumonia*, *Bronchopneumonia* ("Pneumonia,"

If the certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A.1. the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 3 1930  
BUREAU V

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			02644			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Baltimore</u> (No. <u>1</u> )			St. <u>1</u> Ward <u>1</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Baby Lulu Kruller</u>			Registration Dist. No. <u>33</u>					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>						
6 DATE OF BIRTH <u>3</u> <u>18</u> , 19 <u>30</u> (Month) (Day) (Year)								
7 AGE <u>Stillborn</u> If LESS than 1 day, hrs. yrs. mos. ds. or min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)								
9 BIRTHPLACE (State or country) <u>Maryland</u>								
10 NAME OF FATHER <u>Charles Edward Kruller</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>								
12 MAIDEN NAME OF MOTHER <u>Mrs. Margaret Kruller</u>								
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____								
15 Filed <u>Mar 20 1930</u> <u>10mdeare</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>March 18th 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>3-18-1930</u> to <u>3-18-1930</u> , that I last saw him alive on <u>March 18th 1930</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows: <u>Stillborn</u>								
(Duration) _____ yrs. _____ mos. _____ ds.								
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.								
(Signed) <u>James E. Safford</u> M. D. (Address) <u>1215 E. Lombard</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.								
Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>All Saints</u>						DATE OF BURIAL <u>Mar 20, 1930</u>		
20 UNDERTAKER <u>None</u>						ADDRESS _____		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state, occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930

BUR

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Sparks River (No. 7112)

2 FULL NAME William M. Knight

13568  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♂ 4 COLOR OR RACE C. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED M  
(Write the word)

6 DATE OF BIRTH June - 1888  
(Month) (Day) (Year)

7 AGE 42 yrs. 5 mos. - ds. or LESS than 1 day. hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Domestic  
(b) General nature of industry business, or establishment in which employed or (employer).

9 BIRTHPLACE (State or country) Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Knight  
(Address) 711 J St.

15 Filed Nor. 30 1923 J. McComick Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nor. 30 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nor. 28 1923 to Nor. 30 1923

that I last saw her alive on Nor. 29 1923

and that death occurred on the date stated above, at 1 a m.

The CAUSE OF DEATH \* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

Contributory  
Secondary

(Signed) J. H. McComick M. D.  
Nor 30 1923 (Address) Sparks River

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shury Lane Dec 3<sup>rd</sup> 1923

20 UNDERTAKER ADDRESS

Sam'l H. Chase 1400 Market



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deleter," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer Retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930

BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

78 11 Georgetown Rd.

## PLACE OF DEATH

County BaltimoreVillage or City Beltsville

(No. ....)

St. ....

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marion Earl Knight

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single  
(Write the word)

6 DATE OF BIRTH

October 23rd 1914  
(Month) (Day) (Year)

7 AGE

15 yrs. 10 mos. 10 ds.  
If LESS than 1 day. hrs. or min.)

8 OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Marion M. Knight

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ellen Meredith

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Knight

(Address)

2811 Georgetown Road

15 File

Sept 30 1920R. Kieffer  
Registrar

10151

(182)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 42

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 2nd 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192... to ... 192...

that I last saw him alive on ... 192...

and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH \* was as follows:

Drowning - accidentalContributor  
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) Richard E. Stoughton192... (Address) Relay, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. L. Oliver Cem9/6 1930

20 UNDERTAKER

ADDRESS

Edwin Cook1217 5th Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Teamster," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by falling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 2 1930

BUREAU V

WHEN ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Lansdowne (No. Charleston are St.; Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Knobloch

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX not determined 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Child  
(Write the word)

6 DATE OF BIRTH Dec 22 1930  
(Month) (Day) (Year)

7 AGE 1 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER Chas Knobloch

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Richie B Schneider

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richie B Knobloch(Address) Lansdowne Md

15 Filed Dec 23 1930 Geo McKuffe

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 22 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191, to 191,

that I last saw him alive on 191,and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Premature birth  
at birth 30 1/2 mos  
alive  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) Geo McKuffe M. D.  
Dec 22 1930 (Address) 2151 Paul Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

buried by parents Dec 23 1930

20 UNDERTAKER by parents ADDRESS premises





MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto Co

14700  
(118-2)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 40

Village or City Glenarm (No. RFD)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lillian L. Knox

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Dec. 13, 1930  
(Month) (Day) (Year)

7 AGE ✓ yrs. ✓ mos. 10 ds. or min. ? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Chas. W. Knox

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Brubeck

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. W. Knox  
(Address) Glenarm Md.

15 Filed Dec 23 19230 J. H. Linsch Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 23, 1930  
noon 13<sup>th</sup> (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on Dec 23, 19230

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH \* was as follows: Intestinal Obstruction

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Chas. W. Knox M. D.  
Dec 23, 1930 (Address) Chrysiville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pandewood Md. DATE OF BURIAL Dec. 24, 1930

20 UNDERTAKER Clarence E. Arthur ADDRESS Fork Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 3 1931

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore05287 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville Spring Grove Hospital Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Barbara Koch

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)6 DATE OF BIRTH Dec. 15, 1853  
(Month) (Day) (Year)7 AGE 76 yrs. 3 mos. 2 ds. or 2 min.?  
If LESS than 1 day.....hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Germany10 NAME OF FATHER Michael Anon11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Margaret Beller13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Anna Smith  
(Address) 6413 Cecelia Ave Ragsburg15 Filed 5/6 1930 H B Anderson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov. 4, 1929 to May 6, 1930  
that I last saw her alive on May 5, 1930and that death occurred on the date stated above, at 7 A. m.  
The CAUSE OF DEATH \* was as follows:Pulm Tuberculosis  
(Duration) yrs. 3 mos. ds.Contributory Secondary Pneumonia (Pulm)  
(Duration) yrs. mos. ds. 1 ds.(Signed) Doc E Garrett M. D.  
May 6, 1930 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 4 mos. 1 ds. In the 55 yrs. mos. ds.Where was disease contracted, it not at place of death? In BaltimoreFormer or usual residence 6413 Cecelia Ave Ragsburg Md19 PLACE OF BURIAL OR REMOVAL Holy Redeemer DATE OF BURIAL May 9, 193020 UNDERTAKER Mrs. C. Miller & Son ADDRESS 2334 Jefferson St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Balto.Village or City Essex (No. 173)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44

St. Myrtle Ave. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jerry Charles Koelbel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Feb. 7, 1930  
(Month) (Day) (Year)

7 AGE 2 yrs. 7 mos. 10 ds. If LESS than 1 day hrs. or min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto. Md.

10 NAME OF FATHER Simon M. Koelbel

11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Theresa Vitak

13 BIRTHPLACE OF MOTHER (State or Country) Checho Slovakia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Simon M. Koelbel(Address) Myrtle Ave.

15 Filed Apr. 18, 1930 John H. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 17, 1930 to Apr. 17, 1930

that I last saw him alive on Apr. 17, 1930

and that death occurred on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH \* was as follows:

Pneumonia

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory  
Secondary

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) James F. Vitak M. D.

Apr. 17, 1930 (Address) Essex, Md.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Hill Cem. DATE OF BURIAL Apr. 18, 1930

20 UNDERTAKER John H. Connolly ADDRESS Essex



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

14701

E

## CERTIFICATE OF DEATH. (129)

129

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *618 Plymouth St.*)*Catonsville*REGISTERED NO. *30*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME

(a) RESIDENCE NO. *618 Plymouth St.*

(Usual place of abode)

WARD *Catonsville 2nd*

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *life*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*F*

4 COLOR OR RACE

*W*

5 Single, Married, Widowed, or Divorced, (write the word)

*Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Frederick W. Stoenig*6 DATE OF BIRTH (month, day, and year) *May 28, 1867*

7 AGE

*73*

Years

Months *6**4*

Days

If LESS than 1 day,.....hrs. or.....min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *at home*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md.*10 NAME OF FATHER *John Gurbel*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Helena 2*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address) *Hilda Steigler*

15

- 1930

C. HAMPSON JONES, M. D.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Dec 3, 1930*

17

I HEREBY CERTIFY, That I attended deceased from

*home*, 19 *30*, to *Dec 3*, 19 *30*.that I last saw him alive on *Nov 30*, 19 *30*.and that death occurred, on the date stated above, at *7 A.* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial infarction*  
*Chlor. pneumonia & heart failure*(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

*decompensation* yrs. mos. *7* ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *clinical findings*(Signed) *Frederick W. Stoenig* M. D., 19 (Address) *704 N. Charles St.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Southern Park*

DATE OF BURIAL

*12/6 1930*

20 UNDERTAKER

*H. B. Cunningham* *P. P. P. P. P.*

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 5 - 1930

COPY SENT TO LOCAL REGISTRAR

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.:1

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is Epidemic cerebrospinal meningitis); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



WRITE HERE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, and EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Balto

01397

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 2

Village or City Merridale (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Joseph Kohlhepp

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Sept 23, 1 855 (Month) (Day) (Year)

7 AGE 74 yrs. 4 mos. 8 ds. or min. 7 (If LESS than 1 day, hrs.)

8 OCCUPATION (a) Trade, profession or particular kind of work Retired (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cumberland Md

10 NAME OF FATHER Michael Kohlhepp

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Anderson  
(Address) 3009 Maryland Lane

15 Filed Feb 22 1930 B. Mattfeldt Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 21, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1, 1930 to Feb 21, 1930, that I last saw him alive on Feb 21, 1930.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows: Cerebral hemorrhage

Contributory Secondary Atherosclerosis (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) P. M. Henning M. D. Feb 22 1930 (Address) Baltimore, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rosedale Park DATE OF BURIAL Feb 21, 1930

20 UNDERTAKER W. J. Schinner of North Ave ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

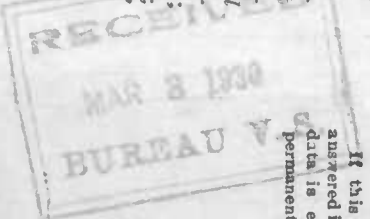
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Scarlatina*; *pneumonia*; *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., etc.* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis; tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

06481

(31)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 33

Village or City Reisterstown (No. Int. Pleasant Lan. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lubov Kamen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, ☒ married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 26, 1887 (Month) (Day) (Year)

7 AGE 42 yrs. 10 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Housework (b) General nature of industry business, or establishment in which employed or (employer) Home

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER Isaac Brodowski

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Kolomaitzine

13 BIRTHPLACE OF MOTHER (State or Country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Record (Address)

15 Filed June 13, 1930 H. M. Slade Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 12, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 23, 1929 to June 12, 1930, that I last saw him alive on June 12, 1930, and that death occurred on the date stated above, at 8:15 P.m. The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) 7 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Albert F. Shies M. D.

June 12, 1930. (Address) Reisterstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. 11 mos. 21 ds. In the State 7 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 5102 Queensbury Ave

19 PLACE OF BURIAL OR REMOVAL Hebrew Cemetery DATE OF BURIAL 6-13-, 1930

20 UNDERTAKER Jac Reine, 1439 E. Balt ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		02645		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>		(No.)		Registration Dist. No. <u>41</u>	
Village or City <u>Dundalk</u>		(No. <u>1921</u> <u>New Pittsburgh Ave St.</u>		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Lucie May Koropka</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>January 15, 1929</u> (Month) (Day) (Year)					
7 AGE <u>1</u> yrs. <u>2</u> mos. <u>2</u> ds. or min. If LESS than 1 day hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Dundalk, Md.</u>					
PARENTS	10 NAME OF FATHER <u>Joseph Koropki</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Poland</u>				
	12 MAIDEN NAME OF MOTHER <u>Minnie Abrahamoff</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Poland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Joseph Koropki</u>					
(Address) <u>Dundalk, Md.</u>					
15 Filed <u>3/21/30</u> <u>1930</u> <u>Baltimore</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 23, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>March 17, 1930</u> to <u>March 23, 1930</u> that I last saw him alive on <u>March 16, 1930</u> and that death occurred on the date stated above, at <u>8-30 A.M.</u> The CAUSE OF DEATH * was as follows: <u>Broncho Pneumonia</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. Contributory Secondary <u>none</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. (Signed) <u>Dr. J. E. H. M. D.</u> <u>3-24-1930</u> (Address) <u>Dundalk, Md.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. In the State <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Christ Ev. Luth. Church, Cem.</u>				DATE OF BURIAL <u>Mar. 25, 1930</u>	
20 UNDERTAKER <u>Henry Sander &amp; Sons, Inc.</u>				ADDRESS <u>Baltimore St &amp; Broadway</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

10152

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Parkton

(No.)

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Marlin Roons

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Jan 11, 1908  
(Month) (Day) (Year)

7 AGE

22 yrs. 8 mos. 9 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Musician

(b) General nature of industry, business, or establishment in which employed or (employer)

Sawmill

9 BIRTHPLACE

(State or country)

Pennsylvania

10 NAME OF FATHER

Brook Roons

11 BIRTHPLACE OF FATHER

(State or country)

Lynchburg, Va.

12 MAIDEN NAME OF MOTHER

Maude Smutzer

13 BIRTHPLACE OF MOTHER

(State or Country)

Lynchburg, Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. G. Zimmerman

(Address)

Lynchburg, Va.

15

Filed

Sept. 27, 1930

W. P. Butler

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 21, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 \_\_\_\_ to \_\_\_\_ 192 \_\_\_\_

that I last saw him alive on \_\_\_\_ 192 \_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Accident  
Automobile collision

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

W. P. Butler (Coroner)

192 \_\_\_\_ (Address) Towson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Schools Church, Pa. Sept. 23, 1930

20 UNDERTAKER

ADDRESS

William Cook 1217 St. Paul St.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonoeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles; Whooping cough; Chronic vesicular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 6 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH ,  
County Baltimore

Village or City Sparrows Point (No. 1)

2 FULL NAME Frank J. Koontz

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 1

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH 10 10 1885  
(Month) (Day) (Year)

7 AGE 44 yrs. 3 mos. 23 ds. or min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Heater  
(b) General nature of industry, business, or establishment in which employed or (employer) Beth Steel Co

9 BIRTHPLACE  
(State or country)

Finland

10 NAME OF FATHER

Do not know

11 BIRTHPLACE OF FATHER  
(State or country)

Finland

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER  
(State or Country)

Finland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Police Dept

(Address) Sparrows Point Md

15 Filed Feb 5 1923 G. L. McEnrick Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 3 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from the time of death to 1923,  
that I last saw him alive on 9:15 am, 1923.

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Myocardium due to ruptured aorta  
Not due to accident or injury.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Jack M. Nicholas M.D.  
Feb 4 1923 (Address) 1022 3rd Sparrows Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lacard Heart Gutty Feb 5 1923  
20 UNDERTAKER John F. Denny ADDRESS 715 2nd St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

It is the duty of the doctor to check over thoroughly and answer in detail. It will prevent further correspondence. All the data is given and must be obtained before the certificate is permanent.

CLARK

WRITE

ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto.</u>		03998		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Reisterstown</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>33</u>	
2 FULL NAME <u>Charles Edward Korman</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>Aug. 17, 1925</u> (Month) (Day) (Year)					
7 AGE <u>4</u> yrs. <u>8</u> mos. <u>7</u> ds. or min. ? If LESS than 1 day.... hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>George W Korman</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>				
	12 MAIDEN NAME OF MOTHER <u>Louise Brothman</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Westminster</u>					
11 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George W Korman</u> (Address) <u>Reisterstown Md</u>					
15 Filed <u>Apr. 25</u> 19 <u>30</u> <u>STMS:lad</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 24, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>4-21-1930</u> to <u>4-24-1930</u> that I last saw him alive on <u>4-24-1930</u> and that death occurred on the date stated above, at <u>10:00</u> p.m. The CAUSE OF DEATH was as follows: <u>Sкартина</u> ..... (Duration) ..... yrs. .... mos. .... ds. Contributory <u>Bronchopneumonia</u> Secondary ..... (Duration) ..... yrs. .... mos. .... ds. (Signed) <u>Louise S. Saffell</u> M.D. <u>4-25-1930</u> (Address) <u>Reisterstown Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ..... yrs. .... mos. .... da. In the State, ..... yrs. .... mos. .... da. Where was disease contracted, if not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>All Saints</u>				DATE OF BURIAL <u>April 26, 1930</u>	
20 UNDERTAKER <u>Berryman &amp; Sons</u>				ADDRESS <u>Reisterstown</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1920  
BUREAU



WRITE

WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Loseknock No. 2410 Poplar Drive St. \_\_\_\_\_ Ward) \_\_\_\_\_

2 FULL NAME Frederick North

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED widower  
(Write the word)

6 DATE OF BIRTH April 26, 1880  
(Month) (Day) (Year)

7 AGE 83 yrs. 11 mos. 7 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed or (employer) Retired

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER August North

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Conrad

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Phillips  
(Address) 2410 Poplar Drive

Filed 4/2 1930 for Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 16 1930 to Apr 2 1930,  
that I last saw him alive on Apr 2 1930,  
and that death occurred on the date stated above, at 4:00 m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis.

(Duration) \_\_\_\_\_ yrs. 2 mos. 13 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Isaac Le Dickson M. D.  
Apr 2 1930. (Address) 3055 N. North Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Chicago Ill DATE OF BURIAL Apr 3, 1930

20 UNDERTAKER for the dead on San 2178. Pan ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

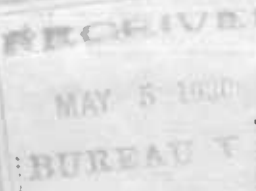
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

231

12204

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Edgemoor (No. Sparrow Point Md Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Rudolph Kotrova

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

April 15, 1888  
(Month) (Day) (Year)

7 AGE

42 yrs. 6 mos. 9 ds. or min.? If LESS than 1 day

8 OCCUPATION

(a) Trade, profession or particular kind of work Sheet mill worker  
(b) General nature of industry business, or establishment in which employed or (employer) Beth Steel Plant

9 BIRTHPLACE

(State or country)

Hungary

10 NAME OF FATHER

Emmy Kotrova

11 BIRTHPLACE OF FATHER

(State or country)

Hungary

12 MAIDEN NAME OF MOTHER

Teresa Pickel

13 BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Kotrova

(Address)

Edgemoor Md

15

Filed Oct. 26 1930 John G. Connelly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Acute Myocarditis(Duration) Unknown yrs. mos. ds.Contributory  
SecondaryNoneAsphyxia (Duration) Unknown yrs. mos. ds.(Signed) Thomas B. Brauman M. D.Oct 24, 1930 (Address) 810 B. 38 Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak LawnOct. 27, 1930

20 UNDERTAKER

ADDRESS

John G. ConnellyEdgemoor Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU

N. B.--Every Item of Information should be carefully supplied ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Bloomfield (No. ....)

2 FULL NAME Joseph H. Kraft.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH November 28 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 7 mos. 9 ds. or min. If LESS than 1 day.....hrs.

OCCUPATION

(a) Trade, profession or particular kind of work *Paan Hanger*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country) MA. N.H. N.Y.

10 NAME OF FATHER *Lieut. H. H. Kault*

11 BIRTHPLACE  
OF FATHER  
(State or country) *Waukegan*

12 MAIDEN NAME  
OF MOTHER *Isadora*

13 BIRTHPLACE  
OF MOTHER *India Penn.*  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mo. Mary Kraft  
(Address) 400 Kinsman - Hildreth

15 Filed April 24 1923 U.S. District Court  
U.S. District Court Registrar

04000 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

Village or City Blountfield (No. Starkins Ave St.          Ward         ) (If death occurred in a hospital or institution         )

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April* *20*, *1936*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Sept. 13, 1928 to April 20, 1930  
that I last saw him alive on April 19, 1930

and that death occurred on the date stated above, at 3:10 p.m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis

(Duration) 3 yrs. 0 mos. 0 ds.

### Contributory Secondary

.. (Duration) ..... yrs. .... mos. .... da

(Signed) Wm. A. Strauss M. D.  
4/20, 1970 (Address) 1901 Guilford

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,  
if not at place of death? .....

Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL <i>Linden Park Cem.</i>	DATE OF BURIAL <i>April 23, 1928</i>
--	---

20 UNDERTAKER <i>Wm Cook</i>	ADDRESS <i>1217 N. Park</i>
---------------------------------	--------------------------------



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery store; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renalner wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 9 1910  
BUREAU

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec 16<sup>th</sup> 1923

1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) M. D.

Dec. 16 1923 (Address) Sparrows Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIAN's should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JAN 7 1901  
BUREAU

WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

M.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		08980 STATE OF MARYLAND CERTIFICATE OF DEATH (129)		Registration Dist. No. <u>30</u>	
Village or City <u>Catonsville</u> (No. <u>Lanier Hill Lane</u> )		St. _____		Ward _____	
2 FULL NAME <u>Herman Kratz</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>May 7, 1863</u> (Month) (Day) (Year)					
7 AGE <u>67</u> yrs. <u>3</u> mos. <u>15</u> ds. or min. ? If LESS than 1 day.... hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Baker</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Germany</u>					
PARENTS	10 NAME OF FATHER <u>Adam Kratz</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Florence Kratz</u> (Address) <u>Lanier Hill Lane</u>					
15 Filed <u>8/25-1920</u> <u>Al. Schuler</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>August 22, 1920</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>1920</u> , to <u>Aug. 22, 1920</u> , that I last saw him alive on <u>Aug. 22, 1920</u> , and that death occurred on the date stated above, at <u>6:10 A.M.</u>					
The CAUSE OF DEATH was as follows: <u>Chronic Endocarditis</u> <u>Chronic Nephritis</u> <u>Atherosclerosis</u> (Duration) ? yrs. mos. ds. Contributory Secondary <u>Cardiac Decompensation</u> <u>Uremia</u> (Duration) ? yrs. mos. ds. (Signed) <u>Sh. Wising</u> M.D. <u>Aug. 23, 1920</u> (Address) <u>4000 Chmonds. Ave.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. da. In the State, yrs. mos. da. Where was disease contracted, if not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Lorraine Cemetery</u> DATE OF BURIAL <u>Aug. 25, 1920</u>					
20 UNDERTAKER <u>George L. Schwartz</u> ADDRESS <u>2101 Brick. Ave.</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc.; *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report more symptoms or terminal conditions, such as "Asphænia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Fullerton (No. 44) Ridge Ave

2 FULL NAME Margaret Kreutzer

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 43

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 12, 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 0 mos. 19 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry business, or establishment in which employed or (employer) at home

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Dannerman

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Fischer

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Kreutzer  
(Address) Fullerton Ave

15 Filed 6/2 1930 G. A. Fintz M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 20 1930 to May 31, 1930.  
that I last saw him alive on May 31, 1930.  
and that death occurred on the date stated above, at 9:10 P. m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of pyloric end of stomach

(Duration) 5 yrs. 5 mos. 5 ds.

Contributory Retraction of pyloric end  
Secondary to cancer

(Duration) 1 yrs. 11 mos. 11 ds.  
(Signed) Edw. H. Benson M. D.  
6/1/30 1930 (Address) Owens Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Joseph's cemetery DATE OF BURIAL June 3, 1930

20 UNDERTAKER Frank L. Lashmeyer ADDRESS Fullerton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 5 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		10153 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Mount Nelson</u> (No. <u>Mount Nelson Branch</u> )		Registration Dist. No. <u>37</u>	
2 FULL NAME <u>Emma Kruxer</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.) <u>Mid. Tuberculosis Sanatorium</u>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write this word)	
6 DATE OF BIRTH <u>September 19</u> , 1899 (Month) (Day) (Year)			
7 AGE <u>31</u> yrs. <u>0</u> mos. <u>7</u> ds. or LESS than 1 day hrs. min.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>George Carroll</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Emma Cullens</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary Kruxer</u> (Address) <u>703 N. 37th St. Balt. Md.</u>			
15 Filed <u>Sept 27</u> 19 <u>30</u> <u>E. E. Nichols</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>September 26</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>August 16</u> , 19 <u>30</u> , to <u>Sept 26</u> , 19 <u>30</u> , that I last saw her alive on <u>Sept 26</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8:32 P.</u> m.			
The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>0</u> yrs. <u>6</u> mos. <u>(?)</u> ds.			
Contributory Secondary <u>None</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.			
(Signed) <u>John A. Smith</u> M. D. <u>Sept 26</u> 19 <u>30</u> (Address) <u>Mount Nelson Md.</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>1</u> mos. <u>10</u> ds. In the State <u>31</u> yrs. <u>0</u> mos. <u>7</u> ds.			
Where was disease contracted, if not at place of death? <u>Unknown</u>			
Former or usual residence <u>703 N. 37th St. Baltimore, Md.</u>			
19 PLACE OF BURIAL OR REMOVAL <u>St. Marys Hampden</u>		DATE OF BURIAL <u>Sept 29</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Chenoweth &amp; Son</u>		ADDRESS <u>3615 Chestnut</u> <u>ave</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Scirrhus, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 1 1930  
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1 PLACE OF DEATH

County

Baltimore04002 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43

Village or City

Rosedale (No. Philadelphia Rd. St. r. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Annie J. Krotee

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

Sept. 8, 1869  
(Month) (Day) (Year)

7 AGE

60 yrs. 7 mos. 13 ds. or LESS than  
1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

at Home

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

4/221930G. A. Futz

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 21, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Dec. 30, 1929 to Apr. 7, 1930.that I last saw her alive on Apr. 21, 1930.and that death occurred on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH \* was as follows:

Cardiac dilatationContributory  
SecondaryUterus - Schlerosis 2 yrs.  
Chronic Nephritis, Chronic Valvular  
Heart Disease  
(Duration) yrs. mos. ds.

(Signed)

G. W. Meyer M. D.  
Apr. 7, 1930 (Address) 1525 E. 3rd St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

First Lutheran Cemetery April 24, 1930

20 UNDERTAKER

ADDRESS

Frederick Lassapmilton

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 2 1930  
BUREAU

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1 PLACE OF DEATH  
County Baltimore

06483

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 35

Village or City Parkton, Md. No. Route No 2 St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Krout

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) infant

6 DATE OF BIRTH June 22, 1930  
(Month) (Day) (Year)

7 AGE Stillborn mos. 0 ds. 0 If LESS than 1 day 0 hrs. or 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Parkton, Balto., Md.

10 NAME OF FATHER Aber Henry Krout

11 BIRTHPLACE OF FATHER (State or country) Wrensmillers

12 MAIDEN NAME OF MOTHER Mary Jane Bailey

13 BIRTHPLACE OF MOTHER (State or Country) Bluefield Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert L. Hesser, M.D.  
(Address) White Hall Md.

15 Filed June 22, 1930 M. Bortner, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22, 1930  
(Month) 22 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 22, 1930 to June 22, 1930, that I last saw him on June 22, 1930

and that death occurred on the date stated above, at m.  
The CAUSE OF DEATH \* was as follows:

Asphyxiation result of placental haemorrhage  
(Duration) 0 yrs. 0 mos. 0 ds.

Contributory Secondary (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Albert L. Hesser M. D.  
June 23, 1930 (Address) White Hall Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Stillersville Cem DATE OF BURIAL June 23, 1930

20 UNDERTAKER Faltus Albert Krout ADDRESS Parkton Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-s. menin. jctis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Tranition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

02646

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 35

Village or City

White Hall, Md

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Martha E. Kuech

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)widow

6 DATE OF BIRTH

Nov. 28, 1839  
(Month) (Day) (Year)

7 AGE

90 yrs. 3 mos. 20 ds. or \_\_\_\_\_ min.?If LESS than  
1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

At Home

9 BIRTHPLACE

(State or country)

Bald Co Md

10 NAME OF FATHER

Nicholas Stelzy

11 BIRTHPLACE OF FATHER

Bald Co Md

12 MAIDEN NAME OF MOTHER

Elmira Foster

13 BIRTHPLACE OF MOTHER

Bald Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. P. May

(Address)

White Hall Md

15

Filed

Mar 20 1930 M. Bortner  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 18, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

March 1928 to March 18, 1930that I last saw him alive on March 18, 1930and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic Valvular heart disease(Duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

William Bortner

M. D.

Mar 20 1930 (Address) White Hall

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients &amp; Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Foster's AintyMar 20 1930

20 UNDERTAKER

ADDRESS

P. MuehlenbeinWhite Hall Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH  
County Balto.

Village or City Bradshaw, (No. \_\_\_\_\_)

2 FULL NAME Francis Kucharski.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 40

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Singlet  
(Write the word)

6 DATE OF BIRTH July 10, 1896.  
(Month) (Day) (Year)

7 AGE 35 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter.  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE Holland.  
(State or country)

10 NAME OF FATHER Luke Kucharski.

11 BIRTHPLACE OF FATHER Holland.  
(State or country)

12 MAIDEN NAME OF MOTHER Antonia Pawicka.

13 BIRTHPLACE OF MOTHER Poland.  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S.M. Malkowski.

(Address) \_\_\_\_\_

15 Filed 9-17 19230. J. J. H. Gonsch  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 14/30. 1922  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 14/30. 1922 to \_\_\_\_\_ 1922

that I last saw him alive on \_\_\_\_\_ 1922

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Auto. Accident.  
Fractured Skull.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Charles Brown M. D.  
Sept 14 1922 (Address) Kingville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Buffalo, N.Y.

DATE OF BURIAL

11/25, 1925

20 UNDERTAKER

W.W. Chambers.

ADDRESS

Washington

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

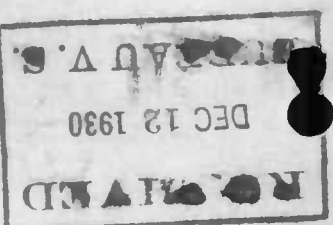
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary, may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Melas (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



1561  
1929  
68

SEE AFFIDAVIT of Mrs. J. D. Malkowski,  
sister of FRANCIS KUCHARSKI, filed  
under MALKOWSKI under date of Decem-  
ber 11, 1930.

*Attach to Cir. Temporarily*



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Balto.

10154

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Colgate (No. 97 East Ave + Martell Ave St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Margaret A. Kulback

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH July 25<sup>th</sup>, 1899  
(Month) (Day) (Year)7 AGE 31 yrs. 1 mos. 19 ds. or min.? If LESS than 1 day... hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Balto. Md.10 NAME OF FATHER Henry Kaiphut11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Kunigunda Neuberg13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Kulback.(Address) East Ave + Martell Ave.15 Filed 9/5/20 192 M. L. ...

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 13<sup>th</sup>, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Aug. 9, 1929 to Sept. 13, 1930, that I last saw him alive on Sept. 12, 1930and that death occurred on the date stated above, at 6:45 p. m.  
The CAUSE OF DEATH \* was as follows:Pulmonary TuberculosisContributory Pulmonary Tuberculosis  
Secondary(Signed) W. E. McManis M. D.  
Sept. 15, 1930 (Address) 3508 Bond St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sacred Heart Cemetery Sept. 16<sup>th</sup>, 193020 UNDERTAKER Lilly + Ziller Inc. ADDRESS 403 S. Wolfe St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 2 1906  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			13569		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			(44-2)		Registration Dist. No. <u>33</u>	
Village or City <u>Rustington</u> (No. <u>MD</u> )			St. <u>MD</u>		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John C. Lambert</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>				
6 DATE OF BIRTH <u>April 21, 1840</u> (Month) (Day) (Year)						
7 AGE <u>89</u> yrs. <u>7</u> mos. <u>4</u> ds. or min.?						
OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Grocer</u> (b) General nature of industry business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>Friedrich Co</u>						
10 NAME OF FATHER <u>Friedrich Lambert</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>						
12 MAIDEN NAME OF MOTHER <u>Catherine Unknown</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Catherine C. Lambert</u> (Address) <u>Rustington MD</u>						
15 Filed <u>Nov 27</u> 1923 by <u>Wm. B. Lambert</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Nov 25, 1923</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 12</u> 1923 to <u>Nov 25</u> 1923 that I last saw him alive on <u>Nov 25</u> 1923 and that death occurred on the date stated above, at <u>8</u> a.m. The CAUSE OF DEATH * was as follows: <u>Chronic Bronchitis</u> (Duration) <u>2</u> yrs. <u>10</u> mos. <u>18</u> ds. Contributory Secondary <u>Chronic Bronchitis</u> (Duration) <u>2</u> yrs. <u>10</u> mos. <u>18</u> ds. (Signed) <u>Wm. B. Lambert</u> M.D. <u>Nov 27</u> 1923 (Address) <u>Keisterstown, Md.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>2</u> yrs. <u>10</u> mos. <u>18</u> ds. In the State <u>2</u> yrs. <u>10</u> mos. <u>18</u> ds. Where was disease contracted, if not at place of death? Former or usual residence.						
19 PLACE OF BURIAL OR REMOVAL <u>Druid Ridge Cemetery</u> DATE OF BURIAL <u>Nov 28, 1923</u>						
20 UNDERTAKER <u>J. F. Ellis Rustington Md.</u> ADDRESS						
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmist (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Alvine No 8489

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 37

Village or City Randallstown (No. Campfield Rd. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George N. Lammlein

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH July 21, 1857  
(Month) (Day) (Year)

7 AGE 73 yrs. 0 mos. 8 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER George Lammlein

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Margt. Gollner

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Home Record.

(Address)

15 Filed July 27, 1930 Mr. Ruffen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1, 1929 to July 29, 1930, that I last saw him alive on July 25, 1930, and that death occurred on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH \* was as follows:  
Coronary Thrombosis

Contributory Secondary (Duration) yrs. mos. ds. Coronary Thrombosis

(Signed) Geo. W. Hemminger M. D.  
July 29, 1930 (Address) 3002 Garrison Bk

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL Aug. 1<sup>st</sup>, 1930

20 UNDERTAKER Mrs. Chas. A. Rohde ADDRESS 2327 E. Duane St.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto</u>		0191 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rehoboth Beach</u>		Registration Dist. No. <u>32</u>	
2 FULL NAME <u>Mary M. Sams</u>		St. <u>md</u> Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widow</u> (Write the word)	
6 DATE OF BIRTH <u>June 11</u> , 18 <u>80</u> (Month) (Day) (Year)			
7 AGE <u>78</u> yrs. <u>7</u> mos. <u>18</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
10 NAME OF FATHER <u>George Reese</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>			
12 MAIDEN NAME OF MOTHER <u>Hanna Reiser</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr Charles A. Reis</u> (Address) <u>14606 Parks Heights ave</u>			
15 Filed <u>Jan 20</u> 19 <u>30</u> <u>D. S. E. Nichols</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan. 19th</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 1</u> , 192 <u>9</u> to <u>Jan 19</u> , 19 <u>30</u> , that I last saw her alive on <u>Jan 18</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>4</u> A. M. The CAUSE OF DEATH was as follows: <u>General carcinomatous</u> <u>Primarily, gastric carcinoma, metastases</u> <u>to liver, lungs, and abdominal viscera.</u> (Duration) yrs. <u>mo.</u> <u>ds.</u>			
Contributory Secondary (Duration) yrs. <u>mo.</u> <u>ds.</u>			
(Signed) <u>James S. Selfell</u> M. D. <u>1-19</u> 19 <u>30</u> (Address) <u>Prattville, Md</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. <u>mo.</u> <u>ds.</u> In the State yrs. <u>mo.</u> <u>ds.</u> Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Druid Ridge Cemetery</u>		DATE OF BURIAL <u>Jan 20</u> 19 <u>30</u>	
20 UNDERTAKER <u>J. F. Elin</u>		ADDRESS <u>Prattville, Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Moscos*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FILED 8 1936  
BUREAU. V. S.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

06484

(74a)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

31

Village or City

Villa Nova

(No.)

Essey Road

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Otto F. Lange

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

Feb.251870

(Month)

(Day)

(Year)

7 AGE

60 yrs. 3 mos. 19

If LESS than

1 day hrs.

da. or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired 3 years

(b) General nature of industry business, or establishment in which employed or (employer)

Restaurateur

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF

FATHER

Charles Lange

11 BIRTHPLACE

OF FATHER

(State or country)

Germany

12 MAIDEN NAME

OF MOTHER

Not known

13 BIRTHPLACE

OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William M. Lange

(Address)

Essey Road Villa Nova

15 Filed

June 18 1923 to E. E. Erichson

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 161920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

June 14

1920 to

June 16

1920.

that I last saw him alive on

June 16 1920

1920.

and that death occurred on the date stated above, at

11:30 P.M.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage(Duration) + yrs. + mos. 3 ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Charles C. Clark

M. D.

June 18

1923 (Address)

3214 Piedmont

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trinity CemeteryJune 19 1920

20 UNDERTAKER

ADDRESS

Henry Sander Sons1710 Fleet St.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Dr. Chas. Clark 3214 Piedmont Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A false data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH,  
County Baltimore

Village or City Owings Mills (No. \_\_\_\_\_)

2 FULL NAME Virginia Margaret P. Lange

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 7, 1922  
(Month) (Day) (Year)

7 AGE 8 yrs. 1 mos. 18 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate Rosewood State  
(b) General nature of industry business, or establishment in which employed or (employer) Training School Owings Mills, Md.

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Charles H. D. Lange

11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Louise M. Pitz

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Institutional Records  
(Address) Rosewood State Training School, Owings Mills, Md.

15 Filed May 25, 1930 Wm. H. H. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 17, 1930 to May 25, 1930, that I last saw her alive on May 25, 1930, and that death occurred on the date stated above, at 4:05 P.M. The CAUSE OF DEATH \* was as follows:

Congenital Idiocy  
Intestinal Obstruction

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 9 ds.

Contributory Broncho-Pneumonia  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 2 ds.

(Signed) George C. Snelair M. D.  
May 25, 1930 (Address) Owings Mills, Md.

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 15 ds. In the 8 yrs. 1 mos. 18 ds.

Where was disease contracted, if not at place of death? At Place of Death

Former or usual residence Baltimore, Md.

19 PLACE OF BURIAL OR REMOVAL Baltimore Cem. DATE OF BURIAL May 28, 1930

20 UNDERTAKER Mrs. Christian Millington ADDRESS 2334 Jefferson St.

REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is filled out thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 20 1910  
BUREAU OF VITAL STATISTICS  
U. S. DEPARTMENT OF COMMERCE

WRITE ONLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			05289 (162)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Providence</u> (No. _____, St.; _____ Ward)			Registration Dist. No. <u>43</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
2 FULL NAME <u>Infant Campbell</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Female</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)				
6 DATE OF BIRTH <u>May 24, 1930</u> (Month) (Day) (Year)								
7 AGE _____ yrs. _____ mos. _____ ds.				If LESS than 1 day, / hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment to which employed (or employer)								
9 BIRTHPLACE (State or country) <u>Maryland</u>								
PARENTS	10 NAME OF FATHER <u>George Campbell</u>							
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>							
	12 MAIDEN NAME OF MOTHER <u>Marie Eckmeyer</u>							
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Marie Campbell</u> (Address) <u>Providence</u>								
15 Filed <u>5/25, 1930</u> <u>G A Fenty</u> REGISTRAR								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>May 24, 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended deceased from <u>May 24, 1930</u> to <u>May 24, 1930</u> , that I last saw him alive on <u>May 24, 1930</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Atelactasia</u>								
Contributory <u>Atelactasia</u> Secondary								
(Signed) <u>Samuel C. King</u> , M. D. <u>May 25, 1930</u> Address <u>5631 Harford Rd</u>								
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.								
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>For Luther Cem (St. Ann's, Balto)</u>						DATE OF BURIAL <u>May 25, 1930</u>		
20 UNDERTAKER <u>John Ullrich</u>						ADDRESS <u>2008 Orleans St.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

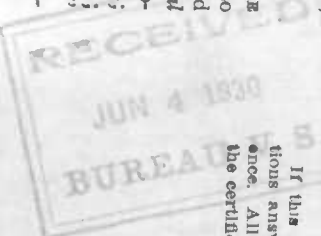
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:—(a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma, Scarcina*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles*; *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as *ACCIDENTAL, SUICIDAL, OR HOMICIDAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

06485

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 43

Village or City Fullerton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles L. Lammann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Dec. 23, 1864  
(Month) (Day) (Year)

7 AGE 65 yrs. 5 mos. 21 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Butcher  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Louis Lammann

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bushman

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. F. Halwig

(Address) \_\_\_\_\_

15 Filed 6/16 1930 G. A. Fritz M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 7, 1930 to June 15, 1930, that I last saw him alive on June 15, 1930

and that death occurred on the date stated above, at 1230 a.m.  
The CAUSE OF DEATH \* was as follows:

Chronic myocarditis  
chronic interstitial nephritis  
(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory barbicide on arm  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 28 ds.  
(Signed) Edw. H. Benson M. D.  
6/16/30 1930 (Address) Greenville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL London Park Cemetery DATE OF BURIAL June 17, 1930

20 UNDERTAKER Fredk. Casap ADDRESS Fullerton



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E.haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Baltimore*

12205

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *41*

Village or City *Calgate* (No. *6720 Holalind Ave.* St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *Caroline Lapin*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Widowed*

6 DATE OF BIRTH *1* *?* *1854*  
(Month) (Day) (Year)

7 AGE *76* yrs. *?* mos. *?* ds. or min. If LESS than 1 day hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work *At Home*  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) *Germany*10 NAME OF FATHER *David Eler*11 BIRTHPLACE OF FATHER (State or country) *Russian Poland*12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (State or Country) *Not Known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Miss Anna Lapin (Daughter)*  
(Address) *6720 Holalind Ave.*

15 Filed *10/27/30* Registrar *Wm. C. ...*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *October 26, 1930*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from *Oct. 1925* to *Oct. 26, 1930*  
that I last saw her alive on *Oct 13, 1930*

and that death occurred on the date stated above, at *4.15 P.* m.  
The CAUSE OF DEATH \* was as follows:

*Chronic Myocarditis*(Duration) *5* yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) *Ans. Krier* M. D.  
*Oct 27 1930* (Address) *Dimmock, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Trinity Cemetery**Oct. 29, 1930*

20 UNDERTAKER

*Henry Sander & Sons, Inc.*

ADDRESS *Baltimore St.*  
*& Broadway*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Camptostor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 6 1930  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY as it appears. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

05290

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 33Village or City Owings Mills (No. ....)

St. .... Ward .... (if death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Frances Lappin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH  
January 2, 1920  
(Month) (Day) (Year)7 AGE  
10 yrs. 4 mos. 3 ds. or If LESS than 1 day .... hrs. .... min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate  
(b) General nature of industry, business, or establishment in which employed or (employer) Penwood State Training School, Owings Mills, Md.9 BIRTHPLACE (State or country) Baltimore, Md.10 NAME OF FATHER Jacob Lappin11 BIRTHPLACE OF FATHER (State or country) Phila., Pa.12 MAIDEN NAME OF MOTHER Sarah Greenbaum13 BIRTHPLACE OF MOTHER (State or Country) London, England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Institutional Records, Penwood State Training School, Owings Mills, Md.15 Filed May 6 1923. at Owings Mills

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1920  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Mar 17, 1924, to May 6, 1920.that I last saw her alive on May 5, 1920.and that death occurred on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH \* was as follows:

Spastic ParaplegiaIdiopathic Epilepsy(Duration) 3 1/2 yrs. .... mos. .... ds.Contributory  
SecondaryPulmonary Edema followingEpileptic Convulsion(Duration) Immediate(Signed) George C. Medsary M. D.May 6, 1920 (Address) Owings Mills, Md.

\*State the 1-is ease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. 11 mos. 6 ds. In the 10 yrs. 4 mos. 3 ds. StateWhere was disease contracted, if not at place of death? ConstitutionalFormer or usual residence Baltimore, Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hebrew Washington Rd May 7, 1920

20 UNDERTAKER ADDRESS

Jack Lewis 1434 C Balto St

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 6 1920



## 1 PLACE OF DEATH

County

Balto.

147

90

0192

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City

Essex

(No.)

Eastern &amp; Deep Creek Cms.

Ward)

(If death occurred in a hospital or institution, give its NAME, its street and number.)

2 FULL NAME

John G. Sauer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Nov. 6th

1866

(Month)

(Day)

(Year)

7 AGE

60

yrs.

2

mos.

23

ds.

IF LESS than

1 day

hrs.

or

min.)

8 OCCUPATION

(a) Trade, profession or particular kind of work

Storekeeper

(b) General nature of industry business, or establishment in which employed or (employer)

Grocery

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Conrad Sauer

11 BIRTHPLACE

OF FATHER

(State or country)

Germany

12 MAIDEN NAME

OF MOTHER

Katherine Ritz

13 BIRTHPLACE

OF MOTHER

(State or Country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Sauer

(Address)

Eastern &amp; Deep Creek Cms.

15

Filed

Jan 31

1930

John G. Connolly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 29

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Jan 29

1930

to

Jan 29

1930

that I last saw him alive on

Jan 29

1930

and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH \* was as follows:

Cyanosis, Tubercular Heart Disease

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Bronchial Asthma

(Duration)

yrs.

mos.

ds.

(Signed)

Harry Hall

M. D.

Jan 31

1930

(Address) Middle River

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

2/1/1930

20 UNDERTAKER

ADDRESS

John G. Connolly

Essex

If more blanks are needed, address State Registrar, 13 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archivist, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Day-er," etc., without more precise specification as *Dealer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrubman*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FILED 1930  
BUREAU OF

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

02647

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonville(No. Spring Grove Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Pauline Lauer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Dec 4, 1866  
(Month) (Day) (Year)

7 AGE

63 yrs. 3 mos. 3 ds. or min. ?  
If LESS than  
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or  
particular kind of workHousewife(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

PARENTS

10 NAME OF  
FATHERunknown11 BIRTHPLACE  
OF FATHER

(State or country)

Germany12 MAIDEN NAME  
OF MOTHERunknown13 BIRTHPLACE  
OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lena Enwald

(Address)

900 Woodbourne Ave

15

filed

2/91930St. Andrew

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 7, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
Feb. 15 1930, to March 7 1930.that I last saw her alive on March 7 1930.and that death occurred on the date stated above, at 6:25 P m.

The CAUSE OF DEATH was as follows:

Atherosclerosis - capillary  
FibrosisContributory  
SecondaryCh. Inter Nephritis  
(Duration) .... yrs. .... mos. 20 ds. 7

(Signed)

Robt E. Garrett M. D.March 8, 1930 (Address) Catonville Md\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury; and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents)At place of death ... yrs. - mos. 20 da. In the 40 yrs. .... mos. .... da.  
StateWhere was disease contracted, In Baltimore  
if not at place of death?Former or usual residence 900 Woodbourne Ave

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kirkwood Cemetery April 10  
1930

20 UNDERTAKER

ADDRESS

George Schilling & Sons 1126 E. Monument

If more blanks are needed, address State Registrar, 16 W Saratoga St., Balto. Requesting V S No 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

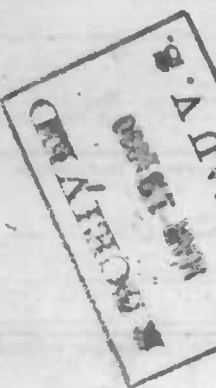
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachea," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is pronounced final.



PLACE OF DEATH

County

02648

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City

(No. 225 Church Lane)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

1 HEREBY CERTIFY, That I attended the deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory Secondary

(Signed)

M. D.

(Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the State

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc.*; *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Dr. Richards & E.

1402 Riverside Road 194

Adelma Ave. N.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

05291

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Pikesville (No. 225 Church Lane St.        Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Isabella Thompson Laughlin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Dec 22, 1841  
(Month) (Day) (Year)

7 AGE 88 yrs. 4 mos. 23 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Baltimore Md

10 NAME OF FATHER Samuel F. Laughlin

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabella Thompson

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt. B. Laughlin

(Address) 225 Church Lane

15 Filed May 14 19230 D. E. Nichols  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 12, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 30 19230 to May 13 19230

that I last saw him alive on May 13, 19230

and that death occurred on the date stated above, at 10 PM m.  
The CAUSE OF DEATH \* was as follows:

Myocarditis

(Duration) ? yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Scurvy

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) E. E. Nichols M. D.

May 14 19230 (Address) Pikesville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Longdon Park

DATE OF BURIAL May 16 1930

20 UNDERTAKER North

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coul mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

JUN 2 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Dr. E. E. Nichols  
1402 Reservoir Ave

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATH07715  
(21)Registration Dist. No. 38Village or City EUDOWOOD SANATORIUM, TOWSON, MD. (No.)St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Robert Nicholas Lorraine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>m</u>	4 COLOR OR RACE <u>w</u>	5 SINGLE, MARRIED, WIDOWED, X OR DIVORCED (Write the word)
-------------------	-----------------------------	---

6 DATE OF BIRTH May 3, 1887  
(Month) (Day) (Year)7 AGE 74-2 yrs. 27 mos. 27 ds. or 1 day 27 hrs. min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Salesman  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Georgia10 NAME OF FATHER Robert Thomas Lorraine11 BIRTHPLACE OF FATHER (State or country) md12 MAIDEN NAME OF MOTHER Clementine Haddaway13 BIRTHPLACE OF MOTHER (State or Country) md14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records -- Personal History  
(Informant) 1Eudowood Sanatorium, Towson, Maryland  
(Address)15 Filed July 30, 1930 W. P. Bridges Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 30, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 29, 1930 to July 30, 1930, that I last saw him alive on July 31, 1930, and that death occurred on the date stated above, at 7:25 a.m. The CAUSE OF DEATH \* was as follows:Tuberculosis (Pulmonary)Severe  
(Duration) 1 yrs. 2 mos. 27 ds.Contributory  
Secondary(Signed) W. A. Bridges M. D.  
1930 (Address) Towson, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 2 mos. 27 ds. In the State 1 yrs. 2 mos. 27 ds.Where was disease contracted, if not at place of death? Unknown

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Easton Maryland DATE OF BURIAL Aug 1<sup>st</sup>, 193020 UNDERTAKER Stewart & Mowbray ADDRESS 108 W. North Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocer; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Backersville Md

2 FULL NAME Ernest Albert Lawrence

(129)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 37

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 5 1871  
(Month) (Day) (Year)

7 AGE 59 yrs. 2 mos. 17 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) From laborer

9 BIRTHPLACE (State or country) Canada

10 NAME OF FATHER Frederick John Lawrence

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Hannah Lawrence

13 BIRTHPLACE OF MOTHER (State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Hannah Lawrence  
(Address) Backersville Md

15 Filed June 25 1920 B. R. Benson Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 14 1920 to June 22 1920  
that I last saw him alive on June 22 1920

and that death occurred on the date stated above, at 20 m.

The CAUSE OF DEATH \* was as follows: Chronic Nephritis

Contributory Secondary Exhaustion & Dilatation of Heart  
(Duration) yrs. 6 mos. 22 ds.

(Signed) J. R. Benson M. D.  
June 22 1920 (Address) Backersville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bosley's Cem. DATE OF BURIAL June 25 1920

20 UNDERTAKER John Benson Sons ADDRESS Towson

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal meningitis*; *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

06487

(74-a)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38

Village or City Lutherville (No. Cor. Kurtz & North Aves. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME George E. Lawton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 8, 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 1 mos. 26 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Grafton, West Virginia

10 NAME OF FATHER Charles T. Lawton

11 BIRTHPLACE OF FATHER (State or country) Vermont

12 MAIDEN NAME OF MOTHER Almira Wheeler

13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Theresa A. Lawton

(Address) Lutherville, Md

15 Filed June 5 1920 W. P. [Signature] Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 4, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 28, 1920 to June 4, 1920, that I last saw him alive on June 4, 1920,

and that death occurred on the date stated above, at 11:30 A. M.  
The CAUSE OF DEATH \* was as follows:

Atherosclerosis

(Duration)  yrs. mos. ds.  
Contributory Arteriosclerosis  
Secondary

(Duration)  yrs. mos. ds.  
(Signed) [Signature] M. D.  
June 5 1920 (Address) Sarban, Md

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

6/6, 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears 805 N. Calvert

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, as *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report, specifically, the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "E.haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 14 1930  
BUREAU

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2—FULL NAME

(a) RESIDENCE NO.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant  
(Address)

15

Filed

Feb 9

19 30

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 8 30, to Feb 6 30, 1930.

that I last saw him alive on Feb 6 1930

and that death occurred, on the date stated above, at 1:40 p.m.

The CAUSE OF DEATH\* was as follows:

arterio sclerosis

CONTRIBUTORY  
(Secondary)

(duration) 2 yrs. mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual signs

(Signed) J. B. Byrd, M. D.

2-8-1930 (Address) 616 W. Woodington

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Mistral Cemetery Feb 10 1930

20 UNDERTAKER

ADDRESS

J. B. Byrd 1450 W. Baltimore St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be fully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Byrd

01399

616 W. Woodington

32



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assn.]

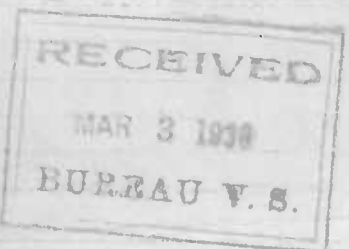
**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds. Never report mere symptoms or terminal conditions, such as "As themia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Calgate, Md. (No. 220) Martelt West ave St. 44 Ward 44 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Agnes M. Leach

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 11, 1879  
(Month) (Day) (Year)

7 AGE 51 yrs. 5 mos. 6 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Poland

10 NAME OF FATHER Michael Prochacz

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Woyciechowski

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aron Leach  
(Address) Martelt West ave

15 Filed Sept. 17 19230 John G. Connolly  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 17, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1, 19230, to Sept 17, 19230, that I last saw her alive on Sept 17, 19230.

and that death occurred on the date stated above, at 3.10 A.M.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of Breasts  
(Duration) 2 yrs. 6 mos. ds.

Contributory  
Secondary

(Duration) 2 yrs. 6 mos. ds.  
(Signed) Harace B. Titlow M. D.  
Sept 17, 19230 (Address) 315 S. Highland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ys. mos. ds. In the State ys. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart of Mary DATE OF BURIAL September 20 19230  
20 UNDERTAKER George A. Weber ADDRESS 205 S. Ann st.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		02649		STATE OF MARYLAND	
County <u>Baltimore</u>		(47)		CERTIFICATE OF DEATH	
Village or City <u>Cockeysville</u> (No. _____)		Registration Dist. No. <u>837</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary E Seaf</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>			
6 DATE OF BIRTH <u>Feb. 16, 1859</u> (Month) (Day) (Year)					
7 AGE <u>71</u> yrs. — mos. <u>13</u> ds. or min. 2					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Balto. Co., Md.</u>					
10 NAME OF FATHER <u>Aguilla Fishpaw</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Balto. Co., Md.</u>					
12 MAIDEN NAME OF MOTHER <u>Mary Wooden</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Balto. Co., Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Mr. John Seaf</u> (Address) <u>Cockeysville, Md.</u>					
15 Filed <u>March 3, 1930</u> <u>B. B. Beatty</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 1, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 13, 1927</u> to <u>Nov 1, 1928</u> that I last saw him alive on <u>Feb. 27, 1928</u> and that death occurred on the date stated above, at <u>3:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Goose home - Malignant</u> <u>Gland + Stomach, primary in</u> <u>left breast. Recurrence in axilla and left chest,</u> <u>after 20 months.</u> (Duration) <u>2</u> yrs. <u>7</u> mos. <u>28</u> ds. <u>Pulmonary carcinoma</u> Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Wm. C. Bayson</u> M. D. <u>Wm. C. Bayson</u> (Address) <u>Cockeysville, Md.</u>					
*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Jessops M. E. Church</u> DATE OF BURIAL <u>Mar. 4, 1930</u>					
20 UNDERTAKER <u>Wm. C. Bayson + Son</u> ADDRESS <u>Sparks, Md.</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

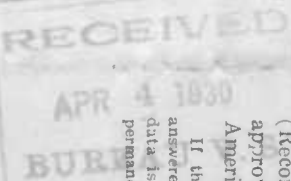
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, House-keeper, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corioma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. AGE should be stated-EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			04003		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			(90)		Registration Dist. No. <u>31</u>	
Village or City <u>Randallstown</u>			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Catherine L. Lee</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>July 20, 1860</u> (Month) (Day) (Year)						
7 AGE <u>69</u> yrs. <u>9</u> mos. <u>3</u> ds. or _____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Maryland</u>						
10 NAME OF FATHER <u>Thomas E. Buckingham</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						
12 MAIDEN NAME OF MOTHER <u>Isabelle Barnes</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ruth A. Clageth</u> (Address) <u>Randallstown</u>						
15 Filed <u>4/24</u> 192 <u>3</u> <u>John H. Butler</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>April 23, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from _____ 192 <u>2</u> to _____ 192 <u>2</u> , that I last saw him _____ alive on _____ 192 <u>2</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Acute dilation of heart</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Signed) <u>Amos H. Jones</u> M.D. <u>April 23, 1930</u> (Address) <u>Baltimore, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Springfield Cemo.</u>					DATE OF BURIAL <u>Apr. 26, 1930</u>	
20 UNDERTAKER <u>Keen &amp; Low</u>					ADDRESS <u>Sylkesville, Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *An accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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CAUTION

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1 PLACE OF DEATH  
County Baltimore

04004 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Edgemere (No. Sparrow Point Rd) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Catherine May Lee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Jan 16, 1905  
(Month) (Day) (Year)

7 AGE 25 yrs. 2 mos. 8 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework at home  
(b) General nature of industry, business, or establishment in which employed or (employer) home

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER George Therrick

11 BIRTHPLACE OF FATHER (State or country) Salem, Conn.

12 MAIDEN NAME OF MOTHER Cora Diamond

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Raymond V. Lee

(Address) Edgemere 2nd

15 Filed Apr. 4 1930 G. M. McInerney Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 1 1930 to April 2 1930, that I last saw her alive on April 2 1930,

and that death occurred on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH \* was as follows:

Squamous cell carcinoma of cervix uteri.  
General abdominal metastases.  
(Duration) ? yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Agonal & Rectal  
Secondary Hemorrhage (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 21 ds.

(Signed) Louis N. Gollen M. D.  
April 3 1930 (Address) Sparrow Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Carmel April 6 1930

20 UNDERTAKER ADDRESS

John T. Denny 715 1/2 St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably suicide*. The nature of the injury, Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

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1 PLACE OF DEATH  
County Baltimore

14213

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 01Village or City Granite (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Arthur George Lehmann

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 22, 1924  
(Month) (Day) (Year)

7 AGE 6 yrs. 6 mos. 1 ds. or 1 day hrs. min.?  
If LESS than 1 day

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Me.

10 NAME OF FATHER Alfred A. Lehmann

11 BIRTHPLACE OF FATHER (State or country) Kansas

12 MAIDEN NAME OF MOTHER Martha Fisher

13 BIRTHPLACE OF MOTHER (State or Country) N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. G. Lehmann(Address) Granite Me.

15 Filed Nov 23, 1930 M. H. Buppert  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 20, 1930 to Nov. 23, 1930

that I last saw him alive on Nov. 23, 1930

and that death occurred on the date stated above, at 3 A m.

The CAUSE OF DEATH \* was as follows:

Scarlet fever  
(Duration) 6 yrs. 6 mos. 6 ds.

Contributory  
Secondary

(Signed) Dr. E. Martin M. D.  
Nov. 23, 1930 (Address) Randallstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ys. mos. ds. In the State ys. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Granite Pres. Bur. DATE OF BURIAL Nov 23, 1930

20 UNDERTAKER Yreer & Son Inc. Sykesville ADDRESS Me.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 2 1931

BUREAU



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

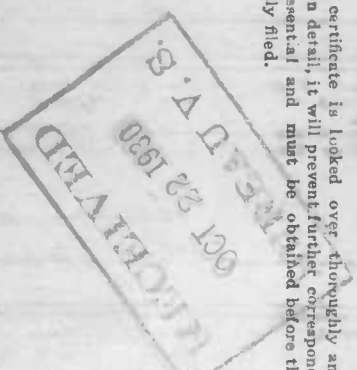
(Approved by U. S. Census and American Public  
Health Association)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Catonsville (No. 104)

2 FULL NAME Catherine Mary Leitz

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 8, 1929  
(Month) (Day) (Year)

7 AGE 81 yrs., 1 mos., 12 ds. or 1 day.... hrs. If LESS than 1 day.... hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer).....

9 BIRTHPLACE (State or country) Balto. Md

10 NAME OF FATHER Frederick Leitz

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kern

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack F. Leitz

(Address) Temple Garden Apt

15 Filed 5/10 1929 H. Andrew Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requestor V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 1, 1929, to May 20, 1930.

that I last saw him alive on May 20, 1930.

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH was as follows:

Atherosclerosis

(Duration) 5 yrs., 5 mos., 5 da.

Contributory and myocarditis  
Secondary

(Duration) 6 yrs., 6 mos., 6 da.

(Signed) J. Frederick Leitz M.D.

May 20, 1930. (Address) Temple Garden

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 5 yrs., 3 mos., 3 da. In the State, 5 yrs., 3 mos., 3 da.

Where was disease contracted, if not at place of death?

Former or usual residence 1001 Broadway St. Balto Md

19 PLACE OF BURIAL OR REMOVAL Western Cem DATE OF BURIAL May 22nd, 1930

20 UNDERTAKER Mrs Charles G Rohde ADDRESS Edmondson  
2327 Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired & yre.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds*; *Bronchopneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Rage," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Randallstown

2 FULL NAME Edward Franklin Leuze

02106

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 31

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~SINGLE~~  
~~MARRIED~~  
~~WIDOWED~~  
~~OR REBORN~~  
(Write the word)

6 DATE OF BIRTH Aug 2, 1868  
(Month) (Day) (Year)

7 AGE 61 yrs. 6 mos. 9 ds. or min. ?  
If LESS than 1 day.... hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Rockville Montgomery Co Md

10 NAME OF FATHER Noah Leuze

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Aigler

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Amelia L. Leuze

(Address) Randallstown Md

15 Filed 2/27 1930 M. H. Duffer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 11, 1930, to Feb 11, 1930, that I last saw him alive on Feb 11, 1930, and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH it was as follows:

Cerebral hemorrhage  
(Duration) ..... yrs. .... mos. 1/2 ds.

Contributory  
Secondary

(Duration) ..... yrs. .... mos. .... da.  
(Signed) Wm. E. Murtree M. D.  
Feb 11, 1930 (Address) Randallstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. .... mos. .... da. In the State Life yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mt Olive Roslyn DATE OF BURIAL Feb 14, 1930

20 UNDERTAKER Joe B Cook ADDRESS 103 N Balto St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 3 1900  
BUREAU V.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

12207

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 2PVillage or City Ruxton (No. Boyce ave)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hilson H. Levering

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

Apr 16 1872  
(Month) (Day) (Year)

7 AGE

57 yrs. 10 mos. 19 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Sash weight  
(b) General nature of industry business, or establishment in which employed or (employer) Mfg.

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Oct 6 19301930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 5, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192\_\_ to \_\_, 192\_\_

that I last saw him alive on \_\_, 192\_\_

and that death occurred on the date stated above, at 4P m.

The CAUSE OF DEATH \* was as follows:

Accidental Fall from a horse

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary(Signed) H. P. Gutz M. D.192\_\_ (Address) 1000 E. Main St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

10 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount, Oct 7, 1930

20 UNDERTAKER

ADDRESS

John A. Mitchell, 1900 E. Main St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.; Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 3 1920  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

06488

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

Village or City Reisterstown Md. (No. 90) Mt. Pleasant Sanat St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Joseph Levin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ✓

6 DATE OF BIRTH April ? 1879  
(Month) (Day) (Year)

7 AGE 51 yrs. 2 mos. ? ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Waiter  
(b) General nature of industry business, or establishment in which employed or (employer) Hotel

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER Leon Levin

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel Levin

13 BIRTHPLACE OF MOTHER (State or Country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1

(Address) 1839 E. Balto St.

15 Filed June 19 1936 18 W. Oliver Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 19 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 25 1930 to June 19 1930  
that I last saw him alive on June 19 1930

and that death occurred on the date stated above, at 10:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Chronic myocarditis

(Duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Dr. Albert F. Shriver Res. N. L. M. D.  
June 19 1930 (Address) Mt. Pleasant Reisterstown Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 25 ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, Balto. Md.  
if not at place of death?

Former or usual residence 20 W. Oliver

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Workmen circle 6/20 1930  
20 UNDERTAKER Joseph Levin ADDRESS 1839 E. Balto St.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered ~~as~~ *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED

PURE

Reid Bureau  
JUN 25 1930  
O.S.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

14703

## CERTIFICATE OF DEATH (49)

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *Co. 115 Symington Ave.* WARD)REGISTERED NO. *50*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

(a) RESIDENCE NO. *115 Symington Ave.* ST. *Catonsville Md.*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *76* yrs. *—* mos. *—* ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Fe.</i>	4 COLOR OR RACE <i>wt.</i>	5 Single, Married, Widowed, or Divorced, write the word <i>Widow</i>
6a If married, widowed, or divorced HUSBAND of <i>Joseph Litz</i> (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) <i>July 9, 1854</i>		
7 AGE <i>76</i>	Years <i>4</i>	Months <i>30</i>
Days <i>—</i>		
If LESS than 1 day, hrs. or min.		

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

*none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*

## 10 NAME OF FATHER

*Not Known*

## 11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md*

## 12 MAIDEN NAME OF MOTHER

*Not Known*

## 13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore Md.*

## 14

Informant

(Address)

*Mrs Harry Dressell  
115 Symington Ave*

## 15

Filed

*Dec 17, 1930**L. M. Wolfelt*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Dec 16, 1930*

17

I HEREBY CERTIFY That I attended deceased from  
*Nov 20*, 19*30*, to *Dec 16*, 19*30*,  
that I last saw him alive on *Dec 16*, 19*30*,  
and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of head of pancreas*(duration) yrs *6* mos *3*

CONTRIBUTORY (Secondary)

(duration) yrs mos ds

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Augustine J. Vondra, M.D.*  
*4878 Edmondson Ave.*

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*W. A. Olive Cemetery  
12-18-30  
Geo Lennbach 525 N. Eynel St*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every jot of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

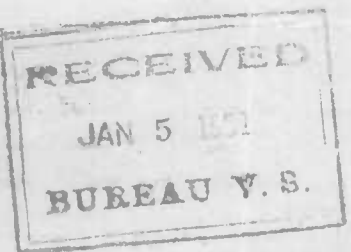
[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm Laborer, Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As theia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

08981  
(92)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Dundalk (No. 47 Admiral Bldg.) Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Simson M<sup>c</sup>Clure Logan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH August 10<sup>th</sup> 1857  
(Month) (Day) (Year)

7 AGE 72 yrs. 11 mos. 22 ds. or min. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Penn

10 NAME OF FATHER Simson P. Logan

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Rebecca Ferninger

13 BIRTHPLACE OF MOTHER (State or Country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lavinia C. Logan  
(Address) 47 Admiral Bldg

15 Filed 8/30/30 1930 Wm. C. McLaughlin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 1<sup>st</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 10-45 A.M.  
The CAUSE OF DEATH \* was as follows:

Coronary Embolus

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory Secondary Arterio-Sclerosis

(Duration) 10 yrs. 0 mos. 0 ds.

(Signed) Wm. C. McLaughlin M. D.

Aug 1 1930 (Address) Dundalk Md.  
State the disease causing death, or, in deaths from violent causes, state (1) Means of injury and (2) Whether accidental, self-inflicted, or homicide.

Frank Williams Coroner

18 LENGTH OF RESIDENCE (For hospitals, institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Parkwood

20 UNDERTAKER John Denny

DATE OF BURIAL Aug 4, 1930

ADDRESS 715 Light St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archivist, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County

Baltimore

Village or City

Brooklandville

FULL NAME

Henrietta Loong

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)widow

6 DATE OF BIRTH

Nov 22 1851  
(Month) (Day) (Year)

7 AGE

79 yrs. 15 mos. 15 ds. or min.?  
If LESS than 1 day, hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)Retired Widow

9 BIRTHPLACE

(State or country)

Baltimore Co

10 NAME OF FATHER

Henry Bronhardt

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Miss Suartz

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Loong

(Address)

Brooklandville

15

Filed Dec 10 1930 by Wm C. Cutler Registrar

14704

48

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 9 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July 9 1930 to Dec 8 1930  
that I last saw him alive on Dec 8 1930and that death occurred on the date stated above, at 2:30 am

The CAUSE OF DEATH \* was as follows:

Carcinoma (Fur & Neck)  
Squamous-celled epithelioma  
of right side of face (Duration) 5 yrs. 15 mos. 15 ds.  
Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Wm C. Cutler M. D.Dec 10 1930 (Address) Towson, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prospect Hill Cem. Dec 11 1930

20 UNDERTAKER

ADDRESS

John Burns & Sons Towson

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The individual worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Painter," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Subacute pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling train; carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A full data is essential and must be obtained before the certificate is permanently filed.

JAN 8 1931

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		10156		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Reisterstown RFD</u>		Registration Dist. No. <u>37</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Margaret Ann Long</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Dec 28, 1957</u> (Month) (Day) (Year)					
7 AGE <u>72</u> yrs. <u>8</u> mos. <u>28</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>Geo W Dearholt</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Sarah Hare</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles Long</u> (Address) <u>Reisterstown Md</u>					
15 Filed <u>Sept 7 1930</u> <u>B B Benson Jr</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 26, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 24 1930</u> to <u>Sept 26 1930</u> that I last saw him alive on <u>Sept 26 1930</u> and that death occurred on the date stated above, at <u>8:25 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Arterio Sclerosis</u> <u>Asthma</u> <u>Arterio Sclerifying</u> (Duration) <u>5</u> yrs. mos. ds.					
Contributory Secondary (Signed) <u>B B Benson Jr</u> M. D. <u>Sept 26 1930</u> (Address) <u>Cockeysville Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.					
Where was disease contracted, if not at place of death? Former or usual residence <u>      </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Grace W. P. Cemetery</u>				DATE OF BURIAL <u>Sept 27 1930</u>	
20 UNDERTAKER <u>John Burns Sons</u>				ADDRESS <u>Towson</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

OCT 6 1930

BUREAU V.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

13570

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonville (No. Spring Grove Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sophie Long

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Jan'y 6, 1861  
(Month) (Day) (Year)

7 AGE 69 yrs. 9 mos. 27 ds. If LESS than 1 day... hrs. or... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Thomas A Long

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Williamna V. Magan

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. D. Long nephew  
(Address) Larchmont N. Y.

15 Filed Nov 3 1930 L. M. J. J. J. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1 1930 to Nov 2, 1930  
that I last saw him alive on Nov 1, 1930

and that death occurred on the date stated above, at 10:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Altered. Sclerosis  
(Duration) 4 yrs. mos. ds.

Contributory High Blood Pressure  
Secondary (Duration) 1 yrs. mos. ds.

(Signed) Robt E. Garrett M. D.  
Nov 3 1930 (Address) Catonville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 0 mos. 1 ds. In the 50 yrs. mos. ds.

Where was disease contracted, if not at place of death? Trappe Md

Former or usual residence Trappe Md

19 PLACE OF BURIAL OR REMOVAL Stord Md DATE OF BURIAL Oct 8, 1930

20 UNDERTAKER Mannie E. J. J. ADDRESS Trappe Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

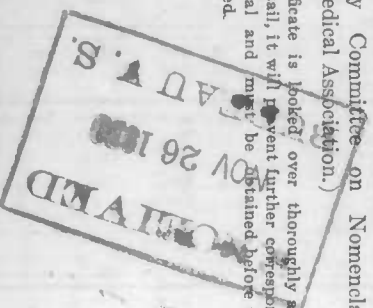
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and may be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH,  
County Baltimore

01400  
49

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 43

Village or City Fullerton (No. Belair Rd.) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME, extend of street and number.)

2 FULL NAME Catherine Mary Jordan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the ward)

6 DATE OF BIRTH Aug unknown 1857  
(Month) (Day) (Year)

7 AGE 72 yrs. 76 mos. unknown ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) Domestic

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER David O'Brien

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Cunningham

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Barton S. Nicholls  
(Address) Fullerton Md.

15 Filed 2/4 1930 B. A. Futz  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 4th 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 20 1929 to Feb 4 1930, that I last saw him alive on Feb 4th 1930,

and that death occurred on the date stated above, at 3 P. m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of the  
jaw & glands of neck  
(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Metastases into lung

(Duration) \_\_\_\_ yrs. 4 mos. \_\_\_\_ ds.  
(Signed) Edw. A. Benson M. D.  
Feb 4th 1930 (Address) Owens Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Wilmington Delaware DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Wm Lynn ADDRESS Wilmington Delaware

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Day-er," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is spoken over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 19 1930  
U. S. DEPT. OF COMMERCE  
BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

01401

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 33Village or City Reisterstown (No. 1 Jewish Home for Consumptives St. 33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Lee Lowenthal

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

## 6 DATE OF BIRTH

February 24, 1879  
(Month) (Day) (Year)

## 7 AGE

50 yrs. 11 mos. 16 ds. or min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work

Collector

(b) General nature of industry business, or establishment in which employed or (employer)

## 9 BIRTHPLACE

(State or country)

Maryland

## 10 NAME OF FATHER

Levi Lowenthal

## 11 BIRTHPLACE OF FATHER

(State or country)

Holland

## 12 MAIDEN NAME OF MOTHER

Theresa Samuels

## 13 BIRTHPLACE OF MOTHER

(State or Country)

Alsace

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Deceased: Lee Lowenthal(Address) 2231 E. Monument St.

## 15

Filed Feb 11 193019301930  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

February 11, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from February 25, 1929, to February 11, 1930.that I last saw him alive on February 11, 1930.and that death occurred on the date stated above, at 12:20 p.m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs. 11 mos. 17 ds.Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Albert F. Shrier M. D.  
Feb. 11, 1930. (Address) Reisterstown, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. 11 mos. 17 ds. In the State 50 yrs. 11 mos. 16 ds.Where was disease contracted, in Baltimore, if not at place of death?Former or usual residence 2231 E. Monument St., Balto.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Arhew CemeteryFeb. 13, 1930

## 20 UNDERTAKER

## ADDRESS

Jack Lewis, 1439 E. Balto.

Thompson Feb 11. 1895  
Spokane

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

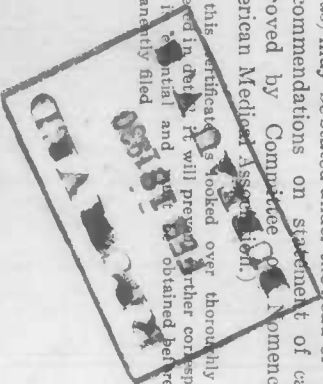
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee of American Medical Association.)

If this certificate is looked over, thoroughly and all questions answered in detail, it will prevent further correspondence. All the data in essential and complete obtained before the certificate is permanently filed





WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07716

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Batonsville (Spring Grove Hospital) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Maggie J. Lucas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Feb'y 14, 1858  
(Month) (Day) (Year)

7 AGE 72 yrs. 5 mos. 1 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Sam'l Boston

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Dorothy Aaron

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. T. Lucas  
(Address) 706 S. 70th St.

15 Filed 7/16 1930 Registrar W. H. Hudson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the decedent from July 15, 1930 to July 16, 1930 that I last saw him alive on July 15, 1930 and that death occurred on the date stated above, at 9 A.M. The CAUSE OF DEATH \* was as follows:

Cerebral Embolism  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Atherosclerosis  
Secondary (Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Paul E. Garnea M. D.  
July 16, 1930 (Address) Batonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. 5 mos. \_\_\_\_ ds. In the State 72 yrs. 5 mos. 1 ds.

Where was disease contracted, if not at place of death? at place of death

Former or usual residence Balto. Md

19 PLACE OF BURIAL OR REMOVAL Woodlawn Cem DATE OF BURIAL 7/19, 1930

20 UNDERTAKER William Cook ADDRESS 1217 N Paul

If more blanks are needed, address State Registrar, 16 W. Seratoga St., Balto., requesting V. S. No. 1. Balto Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

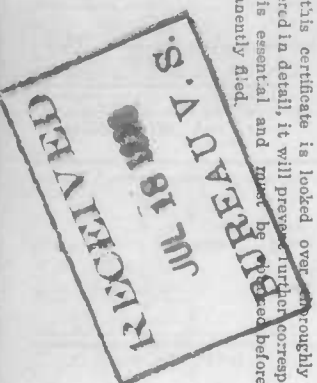
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Senile," etc.), "Dropsy," "Debility" ("Congenital," "Senile," etc.), "Convulsions," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be filled in before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY in PHYSICAL CLAIMS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

0193

(74-a)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

41-

Village or City

Dundalk(No. 85, Dundalk Ave Sts.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ann Rebecca Lusby

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

July41848

7 AGE

81 yrs. 7 mos. 12 ds. or min. ?

If LESS than 1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Thomas Wooten

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Id

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Savage

(Address)

85 Dundalk Ave

15

Filed

1/17/30 192Wm. Carmon

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan171930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 231929

, to

Jan 171930

that I last saw her alive on

Jan 101930and that death occurred on the date stated above, at 2:20 A.M. m.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage, apoplexy

(Duration)

yrs. 1mos. 23

ds.

Contributory Secondary

None

(Duration)

yrs.

mos.

ds.

(Signed)

Arthur

M. D.

Jan 171930

(Address)

Dundalk Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

da.

In the State,

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rosen Park1/20/30

20 UNDERTAKER

ADDRESS

Joseph B. Cook1003 N. Baltimore St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cock mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children not gainfully employed, as *At school* or *At home* (are should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "roup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *Accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 8 1890  
BUREAU





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

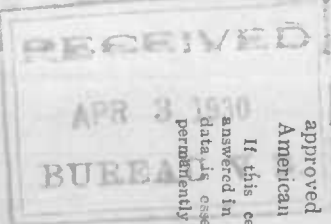
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## PLACE OF DEATH

County

Baltimore

13571

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 37Village or City Lutherville (No. Church Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Jessy Amanda Ly Brand

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widow

6 DATE OF BIRTH

October 11, 1848

(Month)

(Day)

(Year)

7 AGE

82 yrs. 1 mos. 12 ds. or min.

If LESS than

1 day \_\_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

South Carolina

10 NAME OF FATHER

Henry Williams

11 BIRTHPLACE OF FATHER

(State or country)

South Carolina

12 MAIDEN NAME OF MOTHER

Eliza Elliott

13 BIRTHPLACE OF MOTHER

(State or Country)

Georgia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Wm. Canale

(Address)

Lutherville Md.

15

Filed

Nov 25

1920

B. A. Brown

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 23, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 29, 1920 to November 23, 1920that I last saw her alive on November 23, 1920

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Cerebral Haemorrhage(Duration) 1 yrs. mos. ds.Contributory  
Secondary(Duration) 14 yrs. mos. ds.(Signed) J. P. Bellman M. D.Nov 23, 1920 (Address) Towson Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cem, BaltoNov 25, 1920

20 UNDERTAKER

ADDRESS

Edm C Dinkopf & SonSparks, Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

DEC 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Coronoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Drepsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

Village or City Baltimore (No. Rolling Rd)

2 FULL NAME Robert Lynch

10157 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH March 7th, 1900  
(Month) (Day) (Year)

7 AGE 30 yrs. 6 mos. 21 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Auto Repair Shop  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Jacksonville Florida

10 NAME OF FATHER Thomas Lynch

11 BIRTHPLACE OF FATHER (State or country) Jacksonville Florida

12 MAIDEN NAME OF MOTHER Irena Conant

13 BIRTHPLACE OF MOTHER (State or Country) Jacksonville Florida

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna Lynch--Wife

(Address) 717 S. Eaton Street

15 Filed 9/30 1930 George A. Weber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Accidental Death  
Both men were in an airplane (Edward O'Connor & Robert Lynch) operated by Lynch. Tried to make a nosedive; misjudged distance, causing death of both men.  
Contributory Secondary

(Duration) yrs. mos. ds.  
(Signed) George A. Weber M.D.

(Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bah Lawn Cem., Oct 15, 1930

20 UNDERTAKER ADDRESS

George A. Weber 705 S. Ann St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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OCT 4 1904  
BUREAU V. 8



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			02651 (100-a)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>MD Washington</u> (No. ....)			<u>Altamont place</u> (St. ....)		Registration Dist. No. <u>32</u>	
2 FULL NAME <u>John J. Lyons</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>				
6 DATE OF BIRTH <u>July 9, 1844</u> (Month) (Day) (Year)						
7 AGE <u>85</u> yrs. <u>7</u> mos. <u>22</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Hatchman</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Deepwood Mill</u>						
9 BIRTHPLACE (State or country) <u>Ireland</u>						
10 NAME OF FATHER <u>Unknown</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>						
12 MAIDEN NAME OF MOTHER <u>Unknown</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Theodore Lyons</u> (Address) <u>Altamont place</u>						
15 Filed <u>Mich 2</u> 19 <u>30</u> <u>D E E Nichols</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>March 1</u> 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>February 3</u> 19 <u>30</u> to <u>March 1</u> 19 <u>30</u> , that I last saw him alive on <u>March 1</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>3 25 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Broncho pneumonia</u> <u>Age 85.</u>						
Contributory Secondary (Duration) yrs. mos. ds. <u>Senility + Uremia</u> (Signed) <u>H. H. Francis</u> M. D. <u>March 2</u> 19 <u>30</u> (Address) <u>#05 98 Rock St.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.						
19 PLACE OF BURIAL OR REMOVAL <u>St John's Cem New Freedom Pa</u> DATE OF BURIAL <u>March 4</u> 19 <u>30</u>						
20 UNDERTAKER <u>Walter Davis</u> ADDRESS <u>3307 Paine</u>						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

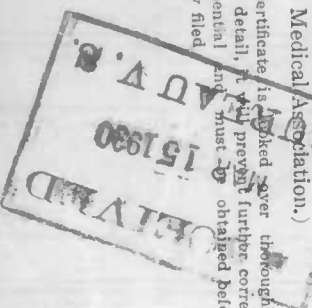
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is applied over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WHILE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED OR DIVORCED (Write the word)

Infant.

6 DATE OF BIRTH

Jan 5, 1930  
(Month) (Day) (Year)

7 AGE

Still Born.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto Co. Md.

10 NAME OF FATHER

Theodore J. Lyons

11 BIRTHPLACE OF FATHER

Parkton Balto Co Md

12 MAIDEN NAME OF MOTHER

Elsie C. Jones

13 BIRTHPLACE OF MOTHER

Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theodore J. Lyons

(Address)

Altamont place

15

Filed

1-6/

1930

D. E. Nichols

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1930, to

that I last saw him alive on

and that death occurred on the date stated above, at 1:30 m.

The CAUSE OF DEATH was as follows:

Stillbirth

Contributory

Secondary

(Signed) H. H. Franklin, M. D.

Jan. 5, 1930 (Address) 28 Beale St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Cem, Hagerstown Jan. 7, 1930

20 UNDERTAKER

ADDRESS

J. Walter Davis 339 Paine St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in the duties of the household only* (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for *wages*, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

County

Balto

08984

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

38

Village or City

Towson (No. 438)

Penna Ave. St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Eliza Mack

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

July 31, 1865  
(Month) (Day) (Year)

7 AGE

65

yrs.

0 mos.

24 ds.

If LESS than  
1 day hrs.  
or min.)

8 OCCUPATION

(a) Trade, profession or  
particular kind of work

House work

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Balto Co.

10 NAME OF  
FATHER

John Cyters

11 BIRTHPLACE  
OF FATHER

(State or country)

Balto. Co.

12 MAIDEN NAME  
OF MOTHER

Eliza Cyters

13 BIRTHPLACE  
OF MOTHER

(State or Country)

Balto. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Meyers

(Address)

438 Penna Ave

15

Filed

Aug 24 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Aug. 20, 1930, to Aug 24, 1930

that I last saw him alive on Aug 24, 1930

and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH \* was as follows:

Acute Uremia

Contributory  
Secondary

(Duration) yrs. mos. ds.

Endocarditis

(Signed)

John W. Laines M.D.

8-24-1930 (Address) 1421 Druid Hill Ave

\*State the Disease Causing Death, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Faugh Chappell

8/28/1930

20 UNDERTAKER

ADDRESS

Byron Wright McAlister



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; (*Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED  
SEP 8 1904  
BU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACS should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Reston No. 14705 Wordley Ave St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME Hannie Mae Rae

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 20, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. 11 mos. 2 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Fayetteville N.C.

10 NAME OF FATHER Duncan L. MacRae

11 BIRTHPLACE OF FATHER (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ann M. MacRae

13 BIRTHPLACE OF MOTHER (State or Country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. D. Williams  
(Address) 927 N. Charles St

15 Filed Nov 22 1936 Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 22, 1936  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 13 1936 to Dec 22 1936

that I last saw him alive on Dec 21 1936

and that death occurred on the date stated above, at 9 a m.

The CAUSE OF DEATH \* was as follows:

Fracture of Tib. Hip: tripped over a rug in her bedroom, and fell. ew 30  
(Duration) \_\_\_\_\_ yrs. 1 mos. 8 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. M. Black M. D.  
Dec 22 1936 (Address) Reston Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Fayetteville N.C. DATE OF BURIAL Dec 22, 1936

20 UNDERTAKER William Cook ADDRESS 1217 St Paul

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile, etc.), "Dropsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931  
BUREAU V. B.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore  
Village or City Middle River (No. 10, Middlebrook St.; 44 Ward)  
2 FULL NAME Barbara M. Maenan  
Registration Dist. No. 44  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May 21, 1886  
(Month) (Day) (Year)

7 AGE 44 yrs. 0 mos. 16 ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Baltimore City

PARENTS  
10 NAME OF FATHER Charles Kuepf.  
11 BIRTHPLACE OF FATHER (State or country) Germany  
12 MAIDEN NAME OF MOTHER Barbara Kuepf.  
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Charles Kuepf. Kuepf.  
(Address) Middlebrook

15 Filed June 8, 1930 John G. Connolly  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 6, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 6, 1930, that I last saw her alive on June 6, 1930, and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH \* was as follows:

Primary Pulmonary Tuberculosis  
Brain Tumor (Duration) 1 yrs. 0 mos. 0 ds.  
Contributory Pulmonary Tuberculosis  
Secondary Brain Tumor (Duration) 8 yrs. 0 mos. 0 ds.  
(Signed) Dr. J. H. Linder, M. D.  
June 9, 1930 (Address) 330 E. Baltimore

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death 0 yrs. 0 mos. 0 ds. In the State, 0 yrs. 0 mos. 0 ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. John's DATE OF BURIAL June 9, 1930

20 UNDERTAKER St. John's ADDRESS St. John's

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Tin engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. **Women** at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or mischriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 7 1908

BUREAU V S



**N. B.--**Every item of information should be carefully supplied. ACE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. **Exact** statement of **OCCUPATION** is very important. See instructions on back of certificate.

### 1 PLACE OF DEATH

County Baltimore

Village or City Agona, Ind. (No. 1)

2FULL NAME Baby Mahon

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St.: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, <i>Single</i> MARRIED, WIDOWED, OR DIVORCED (Write the word)
------------------------	---------------------------------	--

6 DATE OF BIRTH Oct 1st 1980  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than \_\_\_\_\_  
 \_\_\_\_\_ day \_\_\_\_\_ hrs.  
 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.

8 OCCUPATION

(a) Trade, profession or particular kind of work..... *me*

(b) General nature of industry business, or establishment in which employed or (employer).....

9 BIRTHPLACE  
(State or country) *RI* *P. I.*

10 NAME OF FATHER *James M. Lee*

11 BIRTHPLACE  
OF FATHER  
(State or country) *Shannon Point*

12 MAIDEN NAME  
OF MOTHER *Glenn I. Ross*

13 BIRTHPLACE  
OF MOTHER  
(State or Country) *Shannon Dist*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Yas. Mohan  
(Address) 3 Spencer St

15 Filed Dec 12 1923 G. M. C. (unclear)  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 14, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
Oct 1st 1924 to Oct 1st 1928

that I last saw h in alive on Oct 1st, 1922.

and that death occurred on the date stated above, at 86 m.  
The CAUSE OF DEATH \* was as follows:

*Poemata* (7ms)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

## Contributory Secondary

(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.  
(Signed) Frank C. Gabriel M. D.  
10-1-1981 (Address) Frank C. Gabriel

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.      In the State.....yrs.....mos.....ds.

Where was disease contracted,  
if not at place of death?.....

Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Oct. 1, 1930

20 UNDERTAKER	ADDRESS
John A Moran	Balt.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU V. S.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Coronoma, Sorcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by runaway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 7 1931  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

02653

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

30

Village or City Catonsville (No.

Dupont St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Male Infant of Louis &amp; Addie Mairiel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

March 27, 1930  
(Month) (Day) (Year)

7 AGE

4 mos in Utero  
yrs. mos. ds. or min.?If LESS than  
1 day hrs.  
min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Catonsville Md

10 NAME OF FATHER

Louis Mairiel

11 BIRTHPLACE OF FATHER

(State or country)

Catonsville Md

12 MAIDEN NAME OF MOTHER

Addie White

13 BIRTHPLACE OF MOTHER

(State or Country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Mairiel

(Address)

Catonsville Md

15

File

193

Blanchard  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 27, 19230  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from March 27, 19230 to March 27, 19230 that I last saw him Dead March 27, 19230

and that death occurred on the date stated above, at m. The CAUSE OF DEATH \* was as follows:

4 mos in Utero  
miscarriage  
(Duration) yrs. mos. ds.Contributory  
Secondary(Signed) Marshall B. Wirt M. D.  
March 27, 19230 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mr Mairiel-Funeral

DATE OF BURIAL

March 27, 1930

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

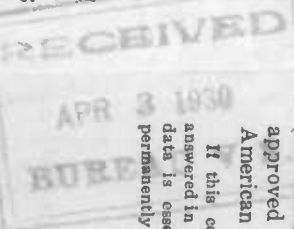
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

10161

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 41

Village or City Dundalk (No. 1829 Kinslip road St.) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George Maldeis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. 23<sup>rd</sup> 1887  
(Month) (Day) (Year)

7 AGE 42 yrs. 10 mos. 25 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Acetylene Burner  
(b) General nature of industry business, or establishment in which employed or (employer) Bethlehem Steel Co.

9 BIRTHPLACE (State or country) Balto Md.

10 NAME OF FATHER Herman Maldeis

11 BIRTHPLACE OF FATHER (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) cc

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amelia Maldeis  
(Address) 1829 Kinslip road

15 Filed 9/20/30 19230 Registrar Wm. L. L. L.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 18<sup>th</sup> 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 18 19230 to Sept 18 19230.  
that I last saw him alive on Sept 18 19230.

and that death occurred on the date stated above, at 6:15 P.M.  
The CAUSE OF DEATH \* was as follows:

Acute Diphtheria (Paratyphoid)  
(Duration) yrs. 1 mos. 3 ds.

Contributory Secondary Gonorrhea  
(Duration) yrs. 2 mos. 5 ds.

(Signed) Laus Vogel M.D.  
9/18 19230 (Address) 16016 Monmouth St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 2 mos. 0 ds. In the State Life yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? at place of death

Former or usual residence 5156 Ave. of Bedford

19 PLACE OF BURIAL OR REMOVAL Oak Lawn DATE OF BURIAL Sept. 22<sup>nd</sup> 19230

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

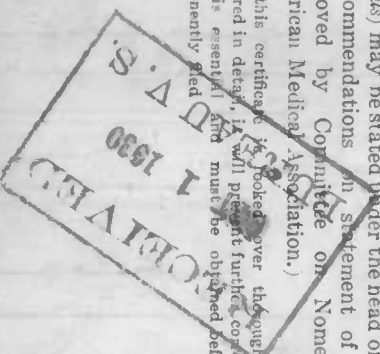
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PARENTS

1 PLACE OF DEATH County <u>Baltimore</u>		10102 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Shane White Hall P.O. Ind.</u> (No. _____) St. _____ Ward _____		Registration Dist. No. <u>35</u>	
2 FULL NAME <u>Elmer Junior Males</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Dec 8, 1929</u> (Month) (Day) (Year)			
7 AGE <u>9</u> yrs. <u>21</u> mos. <u>21</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>none</u>			
9 BIRTHPLACE (State or country) <u>Balto Co. Ind.</u>			
10 NAME OF FATHER <u>Winifred Males</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>York Co. Ind.</u>			
12 MAIDEN NAME OF MOTHER <u>Bessie Williams</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Balto Co. Ind.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Winifred Males</u> (Address) <u>White Hall Ind.</u>			
15 Filed <u>Sept 30, 1930</u> <u>M. J. Males</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Sept 29<sup>th</sup>, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 27, 1930</u> to <u>Sept 27, 1930</u> , that I last saw him alive on <u>Sept 27<sup>th</sup>, 1930</u> , and that death occurred on the date stated above, at <u>11 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Cholera Infantum</u>			
Contributory Secondary <u>Muscular Condition</u> (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <u>Dr. J. H. Free</u> M. D. <u>Sept 30, 1930</u> (Address) <u>Stewartstown Pa.</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Cyrus Chapel</u>		DATE OF BURIAL <u>Oct 2, 1930</u>	
20 UNDERTAKER <u>P. M. Males</u>		ADDRESS <u>White Hall Ind.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 8 1930

BUREAU



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<sup>1</sup> PLACE OF DEATH  
County Baltimore

01403

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 32

Village or City Pikesville (No. 23 Walker Ave) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
<sup>2</sup> FULL NAME Annai B. Mallouee (Mallouee)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 2, 1865  
(Month) (Day) (Year)

7 AGE 64 yrs. 7 mos. 0 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Accountant  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Carroll Co. Md

10 NAME OF FATHER John T. Mallouee

11 BIRTHPLACE OF FATHER (State or country) Balto Co. - Md -

12 MAIDEN NAME OF MOTHER Elysa Annor Buckingham

13 BIRTHPLACE OF MOTHER (State or country) Carroll Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. T. Mallouee  
(Address) Pikesville Md

15 Filed Feb 3 1930 D. E. E. Nichols  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from November 16, 1929, to Feb 2, 1930, that I last saw him alive on Feb 1, 1930,

and that death occurred on the date stated above, at 12:15 P. m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of Stomach  
(Duration) ? yrs. mos. ds.

Contributory  
Secondary

(Signed) E. E. Nichols M. D.  
Feb 2 1930 (Address) Pikesville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Cem DATE OF BURIAL Feb. 4, 1930

20 UNDERTAKER Wm. H. Nichols Sons ADDRESS North Sta

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAR 5 1930  
BUREAU

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1 PLACE OF DEATH County <u>Baltimore</u>		06452		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Leckypville</u> No. <u>078 Md</u>		(77)		Registration Dist. No. <u>34</u>	
2 FULL NAME <u>Josias Maloney</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>May 22</u> , 18 <u>73</u> (Month) (Day) (Year)					
7 AGE <u>57</u> yrs. <u>0</u> mos. <u>14</u> ds. or min. <u>13</u> If LESS than 1 day ____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Merchant</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Employer County Merchant</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Josias Maloney</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Martha Tracey</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr Josias Maloney</u> (Address) <u>Butler, Md</u>					
15 Filed <u>June 6</u> 19 <u>30</u> <u>Eugene F Alban</u> Registrar <u>Deft Loc</u>					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 5</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 10</u> 19 <u>30</u> to <u>June 5</u> , 19 <u>30</u> that I last saw him alive on <u>April 5</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9 A</u> m. The CAUSE OF DEATH * was as follows: <u>Karsakoff disease</u>					
Contributory Secondary <u>Pulmonary Embolism</u> (Duration) <u>1</u> yrs. <u>5</u> mos. <u>10</u> ds.					
(Signed) <u>Thos. P. Benson</u> M. D. <u>June 5</u> 19 <u>30</u> (Address) <u>Leckypville Md</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Black Rock</u>				DATE OF BURIAL <u>June 7</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Wm. C. Burdick &amp; Son</u>				ADDRESS <u>Sparks, Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 2 1930

50

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1 PLACE OF DEATH  
County Balto.

13572

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 43

Village or City Hullerton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Virginia Lee Upman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED ☐ married  
(Write the word)

6 DATE OF BIRTH May 16, 1863  
(Month) (Day) (Year)

7 AGE 67 yrs. 5 mos. 26 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Domestic  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Christopher  
(Address) Hullerton

15 Filed 11/12/1930 Sustona A. Zait  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 12, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1918 1920 to Nov 12, 1920

that I last saw him alive on Nov 11, 1920

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH \* was as follows:

Apoplexy  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. immediate

Contributory  
Secondary

(Duration) 15 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Sustona A. Zait M. D.  
11/12/30 1920 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parkwood Cemetery

Nov. 10, 1930

20 UNDERTAKER

ADDRESS

Frank Esselman & Sons 7401 Belair Rd.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Paysician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 4 1930

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

02107

# STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 31

PLACE OF DEATH

County BaltimoreVillage or City Randallstown (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Wm. J. Mann

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Feb 23 1843</u> (Month) (Day) (Year)		
7 AGE <u>86 yrs. 11 mos. 17 ds.</u> or <u>17</u> min. If LESS than 1 day ____ hrs.		

## 8 OCCUPATION

 (a) Trade, profession or particular kind of work farmer  
 (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

## 9 BIRTHPLACE (State or country)

Virginia

## 10 NAME OF FATHER

Chas. Mann

## 11 BIRTHPLACE OF FATHER (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mannie Jackson

## 13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Mann

(Address)

Granite md

15

Filed

2/10

192

20 M. N. Bupper

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb 9 1930  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from Feb 5 1930 to Feb 9 1930, that I last saw him alive on Feb 9 1930, and that death occurred on the date stated above, at 4300 m.

The CAUSE OF DEATH \* was as follows:

Polar pneumonia(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 4 ds.Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Wm. E. Martin M. D.Feb 10 1930 (Address) Randallstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Upperville Virginia Feb 11 1930

## 20 UNDERTAKER

## ADDRESS

Chas. Wiltshire Upperville Va.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

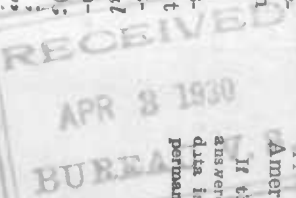
(Approved by U. S. Census and American Public  
Health Association)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At School, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

9, 17

1920

J. F. H. Gonsuch

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Fracture of Skull  
with loss of brain  
matterContributory  
Secondary

(Signed)

Chas. Brown M. D.  
Sept 14/20 (Address) Kingsville Md\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.In the  
State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Solons Cemetery Md Sept 17, 1920

20 UNDERTAKER

ADDRESS

David Dandson Upper Falls

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

Village or City Beadsden Md

2 FULL NAME Julius Maignaud

0197 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 40

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Sept 1861

7 AGE 68 yrs. 4 mo. 7 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed or (employer) Farmer

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs May Veerke

(Address) Beadsden Md

15 Filed 1/13 1930 J. F. H. Horsman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 11 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 28 1929 to Jan 11 1930

that I last saw him alive on Jan 10 1930

and that death occurred on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH \* was as follows:

Myocardial Infarction

Contributory (Duration) yrs. mos. ds. Cardiac Hypertrophy

Secondary Chronic Nephritis

(Signed) E. E. E. E. E. M. D.

Jan 11 1930 (Address) Prosser

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trinity Lutheran Cemetery Jan 14 1930

20 UNDERTAKER

ADDRESS md

Howard K McElm abingdon

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* avoid use of "Croup"); *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* "Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified--Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

02654

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Spencer (No. 1320) Forest Road

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Still born infant. (twins) Markel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single

6 DATE OF BIRTH March 17th, 1930  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. or — min. If LESS than 1 day — hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER George Markel

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Edna M. Seibert

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Edna M. Markel

(Address) Spencer

15 Filed Mar. 18, 1930 G. H. McCombs Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on —, 192

and that death occurred on the date stated above, at — m. The CAUSE OF DEATH \* was as follows:

Still born infant (3 mos)  
(twins)

(Duration) — yrs. — mos. — ds.

Contributory  
Secondary

(Signed) G. H. McCombs (Duration) — yrs. — mos. — ds. M. D. Mar. 18, 1930 (Address) Spencer

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sent to Johns Hopkins, 19—

20 UNDERTAKER ADDRESS

Anatomical Laboratory

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer", etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia",

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Echausion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by passing train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 7 1933  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

02655

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 144

Village or City

(No. 1320)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Mar 18 1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH was as follows:

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) M. D.

1923 (Address) Sparrows Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

02656 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Sundalk (No. 1 Morris Circle St.) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Tilton Marley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct 9, 1901  
(Month) (Day) (Year)

7 AGE 28 yrs. 4 mos. 1 wk. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER John T. Marley

11 BIRTHPLACE OF FATHER (State or country) Id.

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or Country) Id.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Marchant

(Address) 1 Morris Circle

15 Filed 3/3/30 Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3. 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 7<sup>th</sup> 1929 to March 2<sup>nd</sup> 1930, that I last saw him alive on March 1<sup>st</sup> 1930, and that death occurred on the date stated above, at 12<sup>30</sup> pm. The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 5 mos. 1 ds.  
Contributory Tuberculosis Peritonitis  
Secondary

(Signed) Chas. C. Hafferty M. D.  
March 2<sup>nd</sup> 1930 (Address) 104 W. Madison St.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 5 mos. 1 ds. In the State 1 yrs. 5 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL March 3, 30

20 UNDERTAKER John Ullrich ADDRESS 2008 Orleans

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

MAR 25 1930

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL. Examples: *Accidental drowning; Struck by railway train—decident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, delirium*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

## 1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. 100 Newburg Ave St. Ward) (If death occurred in a hospital or Institution, give its NAME instead of street and number.)2 FULL NAME Joshua M. Marsden

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married6 DATE OF BIRTH Aug 2 1859  
(Month) (Day) (Year)7 AGE 71 yrs. -1 mos. 24 ds. or min.? If LESS than 1 day8 OCCUPATION  
(a) Trade, profession or particular kind of work Bookkeeper  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Ind.10 NAME OF FATHER John Marsden11 BIRTHPLACE OF FATHER (State or country) Ind.12 MAIDEN NAME OF MOTHER Suzanne Miller13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Joshua Marsden  
(Address) Catonsville Ind.15 Filed 9/26/30 1930 Registrar R. S. Andrews

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 26 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 1929 to Sept 26 1930, that I last saw him alive on Sept. 25, 1930, and that death occurred on the date stated above, at 10 a. m. The CAUSE OF DEATH \* was as follows:Diabetes Mellitus(Duration) 10 yrs. mos. ds.Contributory  
Secondary(Duration) 10 yrs. mos. ds.  
(Signed) Marshall B. West M. D.  
Sept 26 1930 (Address) Catonsville Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ys. mos. ds. In the State ys. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park Cem Sept 29 1930

20 UNDERTAKER ADDRESS

Geo J. Smith 1532 Hellmuth

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 4 1930

BUR



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

10164

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonville (No. Spring Grove Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John W. Marsh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH December 5<sup>th</sup>, 1857  
(Month) (Day) (Year)

7 AGE 72 yrs. 8 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Switch Tender  
(b) General nature of industry business, or establishment in which employed or (employer) Pa. Rd.

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jas. A. Marsh

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Frederick

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Marsh  
(Address) 2939 Huntington Ave.

15 Filed Sept 4 1930 C. H. Mattfeldt  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 3<sup>rd</sup>, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 13 1920 to Sept 3<sup>rd</sup>, 1920, that I last saw him alive on Sept 3<sup>rd</sup>, 1920

and that death occurred on the date stated above, at 3:45 p.m.  
The CAUSE OF DEATH \* was as follows:

Septic Pneumonia

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Septic Infection

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Doc Edw. Garrett M. D.  
Sept 3 1920 (Address) Catonville, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State 72 yrs. 8 mos. 28 ds.

Where was disease contracted if not at place of death? Exp. place of death

Former or usual residence. 2939 Huntington Ave. Catonville, Md

19 PLACE OF BURIAL OR REMOVAL Parkwood

DATE OF BURIAL Sept 6, 1930

20 UNDERTAKER Chenoweth ADDRESS 3615 Chestnut

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rencher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory."

Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1933

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			01404 (31)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Reisterstown</u> (No. <u>Jewish Home f. Consumptives</u> Ward)			Registration Dist. No. <u>33</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Louise Marshall</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>separated</u> (Write the word)						
6 DATE OF BIRTH <u>February 22, 1880</u> (Month) (Day) (Year)								
7 AGE <u>48</u> yrs. <u>11</u> mos. <u>14</u> ds. or min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer)								
9 BIRTHPLACE (State or country) <u>Maryland</u>								
PARENTS	10 NAME OF FATHER <u>August Schleibaum</u>							
	11 BIRTHPLACE OF FATHER (State or country) <u>U. S. A.</u>							
	12 MAIDEN NAME OF MOTHER <u>Louise Wright</u>							
13 BIRTHPLACE OF MOTHER (State or Country) <u>U. S. A.</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE								
(Informant) <u>deceased: Louise Marshall</u> (Address) <u>22 S. Highland Ave</u>								
15 Filed <u>Feb 4</u> 192 <u>30</u> <u>H. M. Seaboard</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>February 4</u> , 19 <u>30</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>August 22, 1923</u> to <u>February 4</u> , 19 <u>30</u> , that I last saw her alive on <u>February 4</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8:30 p.m.</u> The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>10</u> yrs. <u>5</u> mos. <u>14</u> ds.								
Contributory Secondary (Duration) yrs. mos. ds.								
(Signed) <u>Albert F. Shrier</u> M. D. <u>Feb. 4</u> 19 <u>30</u> . (Address) <u>Reisterstown, Md.</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>6</u> yrs. <u>5</u> mos. <u>14</u> ds. In the State <u>48</u> yrs. <u>11</u> mos. <u>14</u> ds. Where was disease contracted, if not at place of death? <u>at home in Balto</u> Former or usual residence <u>22 S. Highland Ave</u>								
19 PLACE OF BURIAL OR REMOVAL <u>Louisa Park</u>						DATE OF BURIAL <u>Feb 7</u> , 19 <u>30</u>		
20 UNDERTAKER <u>W. Cook</u>						ADDRESS <u>1217 St Paul St</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

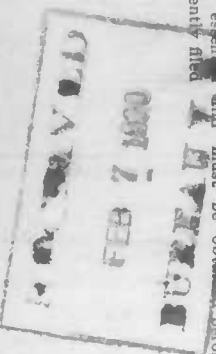
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Solemon*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic nodular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be furnished before the certificate is permanently filed.



*Feb. 6 1901*  
*W. S. D. L. L. L.*

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore County

Village or City Radnorwood (No. \_\_\_\_\_)

2 FULL NAME Mary Haines Marshall

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, x Married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May Eight, 1861  
(Month) (Day) (Year)

7 AGE 67 yrs. four mos. eight ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Aurora Indiana

10 NAME OF FATHER M. L. Haines

11 BIRTHPLACE OF FATHER (State or country) do not know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (State or Country) Aurora Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. C. Rust

(Address) Radnorwood Ind

15 Filed Sept 24 1930 Wm P. Butler Registrar

10837 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 28

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 15<sup>th</sup> 1930 to Sept 26<sup>th</sup> 1930, that I last saw him alive on Sept 25<sup>th</sup> 1930, and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:  
Myocardial Insufficiency

Contributory Arterio Sclerosis (Coronary)  
Secondary Remedy Mutual Insufficiency  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Danise J. E. Thos. Taylor M. D.  
Sept 27 1930 (Address) Towson Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Aurora Indiana DATE OF BURIAL Sept 27 1930

20 UNDERTAKER John Burns Sons ADDRESS Towson



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 8 1930

BUREAU

MARGIN RESERVED FOR BINDING

7 S No. 1

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Baltimore</u>		06493 (90)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Monkton</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>35</u>	
2 FULL NAME <u>Charles H Martenet Sr.</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>June 24, 1930</u> (Month) <u>24</u> (Day) <u>1930</u> (Year)		
6 DATE OF BIRTH <u>Jan 27, 1854</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the decedent from <u>June 19, 1930</u> to <u>June 24, 1930</u> that I last saw him alive on _____, 192____,		
7 AGE <u>76</u> yrs. <u>5</u> mos. <u>27</u> ds. or min.?			and that death occurred on the date stated above, at <u>30</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic mitral insufficiency</u> (Duration) <u>3</u> yrs. _____ mos. _____ ds.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Carpenter, Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Self</u>			Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) <u>Baltimore Md</u>			(Signed) <u>Albert J. Hesser</u> M. D. <u>June 24, 1930</u> (Address) <u>White Hall Md</u>		
10 NAME OF FATHER <u>Charles H Martenet</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore Md</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
12 MAIDEN NAME OF MOTHER <u>Susanna Cross</u>			Where was disease contracted, if not at place of death? Former or usual residence _____		
13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore Md</u>			19 PLACE OF BURIAL OR REMOVAL <u>Western Cemetery</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles H Martenet Jr</u> (Address) <u>2307 E Madison St Baltimore Md</u>			DATE OF BURIAL <u>6/27/1930</u>		
15 Filed <u>June 24th 1930</u> <u>M. Cortes, Md</u> Registrar			20 UNDERTAKER <u>Wm Cook 1219 St Paul St</u>		

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 7 1930

BUREAU

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1 PLACE OF DEATH  
County Balto

Village or City 202 (No. St Helena)

2 FULL NAME Calleen M Martin

0198  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX L 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) -

6 DATE OF BIRTH Jan 5, 1980  
(Month) (Day) (Year)

7 AGE 1 If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Dundalk

10 NAME OF FATHER Frank B Martin

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Janetta Hawley

13 BIRTHPLACE OF MOTHER (State or Country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank B Martin  
(Address) 202 St Helena Ave

15 Filed 1/5/80 1980 W McCarmon  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 5, 1980  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 4 1980 to Jan 5 1980, that I last saw him alive on Jan 4 1980,

and that death occurred on the date stated above, at 8 A m. The CAUSE OF DEATH \* was as follows:

Atelectasis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 1 ds.  
Contributory Secondary none

(Signed) Dr. Rier M. D.  
Jan 5 1980 (Address) Dundalk, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Matthews DATE OF BURIAL Jan 6, 1980

20 UNDERTAKER John Ullrich ADDRESS 2078 Shiloh

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Loobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease, causing death), 29 ds; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

FEB 3 1900  
BUR



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		04007		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>		(21)		Registration Dist. No. <u>33</u>	
Village or City <u>Owings Mills</u> (No. <u>Rosewood State Training School</u> )		St. <u>Ward</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>George Martin, Jr.</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>June 20<sup>th</sup>, 1912</u> (Month) (Day) (Year)					
7 AGE <u>17 yrs. 9 mos. 28 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Inmate of State</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Institution for Feeble Minded</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>George Martin</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>New York</u>				
	12 MAIDEN NAME OF MOTHER <u>Minnie Angle</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Frank W. Keating, Jr.</u>					
(Address) <u>Owings Mills, Md.</u>					
15 Filed <u>April 17</u> 192 <u>3</u> <u>1721</u> <u>MD</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 17<sup>th</sup>, 1923</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 15</u> 192 <u>3</u> to <u>April 17</u> 192 <u>3</u> that I last saw him alive on <u>April 17</u> 192 <u>3</u> , and that death occurred on the date stated above, at <u>3 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>Unknown</u> yrs. ____ mos. ____ ds.					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds. <u>Frank W. Keating, Jr.</u> M. D. <u>April 17</u> 192 <u>3</u> (Address) <u>Owings Mills, Md.</u>					
*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death <u>10 yrs. 2 mos. 1 ds.</u> In the <u>17 yrs. 9 mos. 28 ds.</u> State					
Where was disease contracted <u>At place of death</u> if not at place of death?					
Former or usual residence <u>Hyattsville, Maryland</u>					
19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL <u>Rosewood Cemetery</u> <u>April 18<sup>th</sup>, 1923</u>					
20 UNDERTAKER ADDRESS <u>J. F. Ehlers, Pikesville, Md.</u>					

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Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be entered under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 8 1924

BUREAU

## 1 PLACE OF DEATH

County Baltimore

01405

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 20Village or City Catonsville Spring Grove Hospital (No. 31) (Ward)

(If death occurred in a hospital or institution, give its NAME 1, - instead of street and number.)

2 FULL NAME Mary Martin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)6 DATE OF BIRTH October 9, 1860  
(Month) (Day) (Year)7 AGE 69 yrs. 4 mos. 6 ds. or 1 day 45 hrs. 5 min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Germany10 NAME OF FATHER John Wehner11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Eva May13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Martin (Husband)  
(Address) 1225 N. Bond St.15 Filed Feb 16 1930 C. L. Wolford  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 15, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 7, 1927 to Feb 15, 1930.that I last saw her alive on Feb 14, 1930and that death occurred on the date stated above, at 11:45 p.m.  
The CAUSE OF DEATH \* was as follows:Pulmonary Tuberculosis  
(Duration) 4 yrs. 4 mos. 4 ds.Contributory Involuntal Melancholia  
Secondary (Duration) 2 yrs. 2 mos. 2 ds.(Signed) Robt. O. Garret M. D.  
Feb 16, 1930 (Address) Catonsville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 4 mos. 8 ds. In the 50 yrs. 5 mos. 5 ds.Where was disease contracted at place of death  
it not at place of death?Former or usual residence 1225 N. Bond St. Balt. Md.19 PLACE OF BURIAL OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL 2-15, 193020 UNDERTAKER John Doore ADDRESS 1212 1/2 Pine St. Balt.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary; or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œdema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 3 1930  
BUREAU

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PLACE OF DEATH  
County Baltimore

Village or City Lansdowne (No. \_\_\_\_\_)

Third Ave

St. \_\_\_\_\_ Ward \_\_\_\_\_ (if death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Baby Girl Martini

Registration Dist. No. 42

# PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 25th, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 2 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Lansdowne, Maryland

10 NAME OF FATHER William J. Martini

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Loretta Knochel

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Knochel

(Address) Lansdowne, Maryland

15 Filed July 28 1930 H. Schmoeffer Registrar

# MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 25, 1930 to July 27, 1930  
that I last saw her alive on July 27, 1930.

and that death occurred on the date stated above, at 1:30 A.M.  
The CAUSE OF DEATH \* was as follows:

Prematurity

2 days (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Kenneth B. Boyd M. D.  
July 28, 1930 (Address) 104 W. Madison St.

\*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Loudon Park Cemetery DATE OF BURIAL July 28, 1930

20 UNDERTAKER Harry H. Witzke ADDRESS 4101 Edmondson Ave



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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.

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1 PLACE OF DEATH  
County Baltimore

Village or City Raspensburg (No. Kenwood Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME George Marx

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Nov. 11, 1869  
(Month) (Day) (Year)

7 AGE 61 yrs. 1 mos. 17 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employee)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Marx

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretta Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Augusta Marx  
(Address) Raspensburg Md.

15 Filed 12/20 1930 John E. Fritz M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15, 1930 to Dec 18, 1930

that I last saw him alive on Dec 18, 1930

and that death occurred on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory Arterio Sclerosis  
Secondary

(Signed) C. Vitace M. D.  
Dec. 19, 1930 (Address) Raspensburg

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Jerusalem Luth. Ch. DATE OF BURIAL Dec. 21, 1930

20 UNDERTAKER Frederick L. L. L. ADDRESS 7401 Belair Rd.

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Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

BUREAU V. S.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

14710

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 37

Village or City North (No. 110)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME May Elizabeth Morgan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 20, 1990  
(Month) (Day) (Year)

7 AGE 6 yrs. 8 mos. 8 ds. If LESS than 1 day 2 hrs. or 20 min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm Elsworth Morgan

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mellie E. Deal

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm E. Morgan  
(Address) North Road

15 Filed Dec 6 1920 R. B. Bennett Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 5, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 28 1920 to Dec 5 1920

that I last saw h<sup>e</sup>r alive on Nov 24, 1920

and that death occurred on the date stated above, at 2.40 m.

The CAUSE OF DEATH \* was as follows:  
Pneumonia

Contributory Secondary Pulmonary embolism  
(Duration) yrs. mos. ds. 12 hrs

(Signed) Wm E. Morgan M. D.  
Dec 5 1920 (Address) East Bay View

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lazar Cemetery DATE OF BURIAL Dec 7, 1920

20 UNDERTAKER H. C. Brooks & Son ADDRESS Sparks

Inc

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by passing train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED  
JAN 8 1931  
BUREAU



WRITING MAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N.B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Fulleton (F.D. Catty Hall St. (No. 1612 St.;        Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Masilek

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>      </u>
6 DATE OF BIRTH <u>Dec 30, 1930</u> (Month) (Day) (Year)		
7 AGE <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		If LESS than <u>4</u> day <u>      </u> hrs. OR min. ?

## OCCUPATION

(a) Trade, profession, or particular kind of work       (b) General nature of industry business, or establishment in which employed (or employer)       9 BIRTHPLACE  
(State or country)Maryland

## PARENTS

## 10 NAME OF FATHER

Alfred Masilek11 BIRTHPLACE OF FATHER  
(State or country)Maryland

## 12 MAIDEN NAME OF MOTHER

Edith Clark13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Masilek

(Address)

Fulleton Ind.

## 15

Filed 12/31, 1930 G. A. Fritz M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 30, 1930  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Dec 30, 1930 to Dec 30, 1930  
that I last saw him alive on Dec 30, 1930and that death occurred on the date stated above, at 49 m.

The CAUSE OF DEATH \* was as follows:

Presumptive Birth  
7 month

(Duration) yrs. mos. ds.

Contributory  
SecondaryPresumptive Birth

(Duration) yrs. mos. ds.

(Signed)

Henry A. Fritz

M. D.

Dec 30, 1930 (Address) 5305 Harford Rd

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.  
Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

John Lutterman Dec 31, 1930

## 20 UNDERTAKER

## ADDRESS

Frederick Rosebush 7401 Reber Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

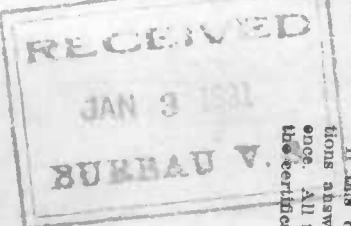
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Saleman*, (b) *Procery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE

ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Balto.

Village or City Fork (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward) \_\_\_\_\_

<sup>2</sup> FULL NAME Christian Mast

08985

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Jan 11, 1855  
(Month) (Day) (Year)

7 AGE 75 yrs. 6 mos. 22 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Penna

10 NAME OF FATHER Samuel Mast

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Barbara Neubauer

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Mast  
(Address) Greenarm Md.

15 Filed Aug 3, 1930 J. H. Linscott  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 10, 1929 to Aug 2, 1930, that I last saw him alive on Aug 2, 1930, and that death occurred on the date stated above, at 4.9 m.

The CAUSE OF DEATH \* was as follows:  
Cerebral hemorrhage

Contributory Secondary Spelap sy (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Walter J. Linscott M. D.  
136 (Address) Baldwin

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Monemite Cem. Tongues DATE OF BURIAL Aug 4, 1930

20 UNDERTAKER Clarence E. Arthur ADDRESS Fork Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Balto

Village or City Stemmers Run

2 FULL NAME Capt. D. W. Mathoney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M

6 DATE OF BIRTH Nov 9, 1851 (Month) (Day) (Year)

7 AGE 78 yrs. 8 mos. 4 ds. or min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Retired Eng. Boat Capt. (b) General nature of industry, business, or establishment in which employed or (employee)

9 BIRTHPLACE (State or country) Baltr. Ind.

10 NAME OF FATHER Daniel Mathoney

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Priscella Morris

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Priscella Mathoney  
(Address) Stemmers Run

15 Filed July 13 1930 John A. Connolly  
Registrar

198 07719

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. Heck Road Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 9, 1930 to July 13, 1930, that I last saw him alive on July 13, 1930

and that death occurred on the date stated above, at 5:30 a.m.  
The CAUSE OF DEATH \* was as follows:

myocarditis  
(Duration) 1 yrs. 7 mos. 7 ds.

Contributory Chronic Sclerotic  
Secondary hypertension  
(Duration) 3 yrs. — mos. — ds.

(Signed) W. S. Speeder M. D.  
July 3, 1930 (Address) 3307 E. Eastern

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Capt. Launborn 7/15/30

20 UNDERTAKER W. J. Moran ADDRESS 3000 E. Balto.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
AUG 6 1930  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Balto.*

08986

188-C

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *44*

Village or City

*Golden Ring (No. 10th Dist)*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Virginia Matrazzo*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Married*

6 DATE OF BIRTH

*May 10th, 1908*  
(Month) (Day) (Year)

7 AGE

*27 yrs. 2 mos. ds. or min.?*

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Va.*

10 NAME OF FATHER

*Craig*

11 BIRTHPLACE OF FATHER

(State or country)

*Va.*

12 MAIDEN NAME OF MOTHER

*Unknown*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Va.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Ralph Matrazzo*

(Address)

*153 N. Patterson Pl. An.*

15

Filed

*Aug. 2, 1930**John B. Connolly*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*August 1st, 1930*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*192* to *192*that I last saw him alive on *192*and that death occurred on the date stated above, at *m.*

The CAUSE OF DEATH \* was as follows:

*Accidental death. Automobile accident. Cerebral Internal Haemorrhage. Struck by an automobile. By person unknown, while walking on road. Old Philadelphia Road. August 1st, 1930.*  
(Duration) yrs. mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

*Jacob Hallman* Coroner M. D.*192* (Address) *Stemmers Run*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Texas Akins Home**Aug 2, 1930*

20 UNDERTAKER

ADDRESS

*John B. Connolly**Essex*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE

ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Baltimore

04008

(57)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. 18 Melrose Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Annie Maria Matthews

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR-DIVORCED (Write the word) <u>Widow</u>
------------------------	-----------------------------------	---

6 DATE OF BIRTH

X X 1862  
(Month) (Day) (Year)

7 AGE

68 yrs. X mos. X ds. or min.  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Domestic Day work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Catonsville Md

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thomas E. Matthews  
Catonsville Md

15

Filed 4-8 1930

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 6<sup>th</sup>, 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1925 1927 to April 6, 19230

that I last saw him alive on March 28<sup>th</sup>, 19230

and that death occurred on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH \* was as follows:

Diabetes mellitus & arteriosclerosis.

Contributory Secondary

Cerebral Hemiplegia  
(Duration) 3 yrs. 5 mos. 18 ds.

"Right" Conc. (Duration) 2 yrs. 9 mos. 9 ds.

(Signed) J. Stuart Macgill M. D.  
April 6 19230 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 5 mos. 18 ds. In the State 3 yrs. 5 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Star Home 4/9 1930

20 UNDERTAKER

ADDRESS

Amuel Hensley W. Biddle

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

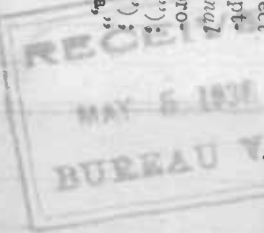
(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chopineumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			13573		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			(9)		Registration Dist. No. <u>30</u>	
Village or City <u>Relay P.O.</u> (No. <u>Cromwell</u> )			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Sarah Matthews</u>						
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Nov 5</u> , 19 <u>30</u> (Month) (Day) (Year)			
6 DATE OF BIRTH _____, 18 <u>51</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Oct 12</u> 19 <u>30</u> to <u>Nov 5</u> , 19 <u>30</u> . that I last saw her alive on <u>Nov 5</u> , 19 <u>30</u> . and that death occurred on the date stated above, at <u>7 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Myocardial infarct</u> <u>Senility</u> (Duration) _____ yrs. _____ mos. _____ ds.			
7 AGE <u>79</u> yrs. _____ mos. _____ ds. or _____ min.?			Contributory <u>Broncho pneumonia</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Domestic</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Senile</u>			(Signed) <u>B. B. Brumfield</u> M. D. <u>Nov 5</u> , 19 <u>30</u> (Address) <u>Edridge</u>			
9 BIRTHPLACE (State or country) <u>Anne Arundel Co. Md.</u>			*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
10 NAME OF FATHER <u>Thomas Countee</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>			Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
12 MAIDEN NAME OF MOTHER <u>unknown</u>			19 PLACE OF BURIAL OR REMOVAL <u>Odd Fellow's Cemetery</u> <u>Edinville Md</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>unknown</u>			DATE OF BURIAL <u>Nov 9</u> , 19 <u>30</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Matthews</u> (Address) <u>Relay Md</u>			20 UNDERTAKER <u>Thomas E. Kelson</u> ADDRESS <u>1303 Preston st</u>			
15 Filed <u>11/7</u> 19 <u>30</u> <u>T. P. Kelson</u> Registrar						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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DEC 5 1930

BUREAU V. B.

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WRITE

FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Sparks Point, Md

2 FULL NAME John A. Maus

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Married  
MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

6 DATE OF BIRTH June 16, 1882  
(Month) (Day) (Year)

7 AGE 47 yrs. 11 mos. 5 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Foreman  
(b) General nature of industry, business, or establishment in which employed or (employer) Steel

9 BIRTHPLACE (State or country) Auburn, Schuylkill Co Pa

10 NAME OF FATHER Henry Maus

11 BIRTHPLACE OF FATHER (State or country) Auburn, Schuylkill Co Pa

12 MAIDEN NAME OF MOTHER Caroline Bashare

13 BIRTHPLACE OF MOTHER (State or country) Inwood, Lebanon Co Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. G. Maus

(Address) Lebanon Pa

15 Filed May 21, 1930 H. G. McManis, Jr  
Registrar

05295

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_ Ward \_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from the death 19221 to May 21, 19230, that I last saw him alive on 19230, and that death occurred on the date stated above, at 3:35 P.

The CAUSE OF DEATH\* was as follows: Cerebral Hemorrhage

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Leah M. Nicholas Brown M. D.  
May 21, 1930 (Address) Sparks Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_

Former or usual residence \_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Lebanon Pa DATE OF BURIAL May 24, 1930

20 UNDERTAKER C. R. Arnold ADDRESS Lebanon Pa

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Baltimore*STATE OF MARYLAND  
14709 CERTIFICATE OF DEATHRegistration Dist. No. *23*

Village or City

(No.)

*Dwings Mills Md*

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Irene Agnes Maxwell*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*female*

4 COLOR OR RACE

*white*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Single*

6 DATE OF BIRTH

*Feb. 27th 1902*  
(Month) (Day) (Year)

7 AGE

*28* yrs. *9* mos. *24* ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

*nurse*

9 BIRTHPLACE

(State or country)

*Wisconsin*

10 NAME OF FATHER

*John Maxwell*

11 BIRTHPLACE OF FATHER

(State or country)

*Scotland*

12 MAIDEN NAME OF MOTHER

*Annie Woodruff*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Wisconsin*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Bryce E. Maxwell*

(Address)

*Dwings Mills Md*

15

Filed *Dec 22 1920*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Dec. 22nd 1920*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Nov. 1, 1920 to Dec. 22, 1920*that I last saw her alive on *Dec. 22, 1920*and that death occurred on the date stated above, at *240 A* m.

The CAUSE OF DEATH \* was as follows:

*Pulmonary Tuberculosis*(Duration) *One* yrs. *3* mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *James H. Saffell* M. D.*12-22-1920* (Address) *Quintston, Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*David Ridge Dec. 24, 1920*

20 UNDERTAKER

ADDRESS

*Harvey Cook 1217 St. Paul*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiopsychal fever (the only definite synonym is "Epidemic cerebro-spinal meningitis"); Diphteria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urtemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Freeland RD. (No. \_\_\_\_\_)

2 FULL NAME Jesse M. McAbee.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Mar 16<sup>th</sup> 1859  
(Month) (Day) (Year)

7 AGE 70 yrs. 8 mos. 3 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer.  
(b) General nature of industry business, or establishment in which employed or (employer) Farmer.

9 BIRTHPLACE (State or country) Balto Co Md.

10 NAME OF FATHER Thos. McAbee.

11 BIRTHPLACE OF FATHER (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Sarah McConnell

13 BIRTHPLACE OF MOTHER (State or country) Don't know.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Wood  
(Address) New Freedom Pa

15 Filed Jan 21 1930 M. Donlin

Registrar

0195

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 35

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 19 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1 1930 to Jan 19 1930

that I last saw him on Jan 17 1930

and that death occurred on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH \* was as follows:

Portia's sufficiency  
(cardiac disease)

Contributory  
Secondary

Chr. Hypertension  
(Duration) 5 yrs. 0 mos. 0 ds.  
S. C. Brown M. D.  
(Signed) Jan 20 1930 (Address) New Freedom

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oakland Cemetery  
Balto Co Md. DATE OF BURIAL Jan 22 1930

20 UNDERTAKER Hartenstein Monemake ADDRESS Med Lion Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE FULLY,

WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Bengies (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2 FULL NAME

Sarah E. McBurney

04005 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH

Oct 21, 1849  
(Month) (Day) (Year)

7 AGE

80 yrs. 4 mos. 5 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Pennsylvania

10 NAME OF FATHER

James Smith

11 BIRTHPLACE OF FATHER

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Margaret Walther

13 BIRTHPLACE OF MOTHER

(State or country)

Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laura Lingenfelder

(Address)

Bengies Ave

15

Filed

April 28 1930 John H. Connelly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 26, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from March 20, 1930 to April 23, 1930, that I last saw her alive on April 23, 1930, and that death occurred on the date stated above, at 1 p.m.

The CAUSE OF DEATH \* was as follows:

Exhaustion & Coma  
Chronic interstitial nephritis, Cerebral

Contributory Secondary

(Signed)

W. H. C. C. C.  
April 28, 1930 (Address) 6 E. Read St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dried Ridge April 28, 1930

20 UNDERTAKER

ADDRESS

Geo J. Smith Hollins

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationery person, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Clothing; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Furn laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH; then any affection with respect to time and causation, though always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "epidemic cerebrospinal meningitis"); Diphtheria avoided use of "croup"; Typhoid fever never report "Typhoid Pneumonia"; Labor pneumonia Bronchopneumonia "Pneumonia."*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Assthena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1918  
BUREAU U. S.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

05293

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 35Village or City Eklo (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thelma Gene McCartha

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 29, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day, 57 hrs. \_\_\_\_\_  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Samuel A. McCartha

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nora Virginia Wheeler

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam McCartha  
(Address) Freeland, P.O. # 2

15 Filed May 30, 1930 Samuel S. Miller  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May - 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 29, 1930 to May 29, 1930, that I last saw him alive on May 29, 1930, and that death occurred on the date stated above, at 8:41 m. The CAUSE OF DEATH \* was as follows:

Premature Birth. (7 mo)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. L. Yagle M. D.  
May 29, 1930 (Address) New Freedom Bk.  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Middletown DATE OF BURIAL May 30, 1930

20 UNDERTAKER R. N. Trabeit ADDRESS Freeland Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary)), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1930  
BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Balto

12208

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

Village or City

Glyndon md

(No. \_\_\_\_\_)

2 S. Dover Rd. E.

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Barba Ellen Mc Carley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Aug

11

1

(Month)

(Day)

(Year)

7 AGE

Unknown 10 years

mos.

ds.

or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Patrol

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

md.

10 NAME OF FATHER

Edward Martin

11 BIRTHPLACE OF FATHER

(State or country)

md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. J. L. Boblitz

(Address)

2 S. Dover Rd. E. Central Ave.

15 Filed

Oct. 23, 1920

H. M. Slade

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 22,

1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Oct 12

1920

to

Oct 22

1920

that I last saw him alive on

Oct 21

1920

and that death occurred on the date stated above, at

3:50 p.m.

The CAUSE OF DEATH \* was as follows:

Coronary Thrombosis

(Duration)

yrs.

mos.

3 ds.

Contributory  
Secondary

Anterior - Inferior

(Duration)

yrs.

mos.

ds.

(Signed)

H. M. Slade

M. D.

Oct 23

1920

(Address)

2 S. Dover Rd. E. Central Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Abingdon Park Cemetery

Oct 25, 1920

20 UNDERTAKER

ADDRESS

Chenoweth &amp; Son

2615 Chestnut

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930

BUREAU

WRITE CAREFULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

⑧ 08982

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Louisa (No. 300 W. Chesapeake Ave. St.        Ward       ) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Baby W. C. Clure

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)       6 DATE OF BIRTH Aug 9 1930  
(Month) (Day) (Year)7 AGE 5 months fetus If LESS than 1 day, hrs.        ds. or min.       8 OCCUPATION  
(a) Trade, profession or particular kind of work         
(b) General nature of industry, business, or establishment in which employed or (employer)       9 BIRTHPLACE (State or country) ind.10 NAME OF FATHER Albert J. W. Clure11 BIRTHPLACE OF FATHER (State or country) ind.12 MAIDEN NAME OF MOTHER Lorothy H. Shepper13 BIRTHPLACE OF MOTHER (State or country) ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. C. M. Clure(Address) 300 W. Chesapeake Ave15 Filed Aug 9 1930 W. P. C. Clure Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 9 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Aug 9 1930that I last saw him alive on Aug 9 1930and that death occurred on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH \* was as follows:

Stillborn(Duration)        yrs.        mos.        ds.Contributory  
Secondary(Duration)        yrs.        mos.        ds.(Signed) W. P. C. Clure M. D.79 1930 (Address) Louisa, ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.Where was disease contracted, if not at place of death?       Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Properly Hall Aug 10 1930

20 UNDERTAKER ADDRESS

John Burns Sons Louisa

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Pealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Other pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little date is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07717  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Village or City Owings Mills (No. 18)

Registration Dist. No. 33

2 FULL NAME Rosa Mae Cool

Rosewood School (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH August 15, 1900  
(Month) (Day) (Year)

7 AGE 29 yrs. 11 mos. 14 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate  
(b) General nature of industry, business, or establishment in which employed or (employer) Rosewood State Training School  
Owings Mills, Md.

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Mae Cool

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Institutional Records  
Rosewood State Training School  
(Address) Owings Mills, Md.

15 Filed July 29 1930 H. M. Slade  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 17, 1924 to July 29, 1930, that I last saw her alive on July 28, 1930, and that death occurred on the date stated above, at 5:30 a.m. The CAUSE OF DEATH \* was as follows:

Inebecile  
Idiopathic Epilepsy  
(Duration) 29 yrs. 11 mos. 14 ds.

Contributory Epileptic Convulsion  
Secondary (Duration) Immediate

(Signed) George C. Medaury M. D.  
July 29, 1930 (Address) Owings Mills, Md.

\*State the cause causing death, or, in deaths from violent causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 22 yrs. 1 mos. 2 ds. In the 29 yrs. 11 mos. 14 ds. State

Where was disease contracted, Consentit  
it not at place of death?

Former or usual residence Maryland

19 PLACE OF BURIAL OR REMOVAL Rosewood Cemetery DATE OF BURIAL July 30, 1930  
20 UNDERTAKER J. F. Elmer ADDRESS Rosewood

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired '6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

08983

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville (No. Spring Grove Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary McCormick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH July 10, 1848  
(Month) (Day) (Year)

7 AGE 82 yrs. 1 mos. 19 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Kennedy

11 BIRTHPLACE OF FATHER (State or country) Ma

12 MAIDEN NAME OF MOTHER Mary Richbert

13 BIRTHPLACE OF MOTHER (State or Country) Ma

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E. McCormick  
(Address) 3618 Old Frederick Rd

15 Filed 30/3/32 1932 W. H. Underhill Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 29, 1930 to Aug. 30, 1930  
that I last saw her alive on Aug. 29, 1930

and that death occurred on the date stated above, at 7:45 A m.  
The CAUSE OF DEATH \* was as follows:

Chr. Inter. Nephritis  
(Duration) 3 yrs. 3 mos. 3 ds.

Contributory Aortic Sclerosis  
Secondary (Duration) 3 yrs. 3 mos. 3 ds.  
(Signed) Robt. E. Garrett M. D.  
192 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 3 mos. 3 ds. In the 82 yrs. 1 mos. 19 ds. State

Where was disease contracted, if not at place of death? In Baltimore

Former or usual residence 3618 Old Frederick Rd

19 PLACE OF BURIAL OR REMOVAL Loudon Park Cem DATE OF BURIAL Sept 1, 1930

20 UNDERTAKER John O. Mitchell & Son ADDRESS 1900 Eulaw Place

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
BUREAU  
JAN 11 1913



WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

Village or City

Freeland. RD.

(No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

35

St. Ward)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Russell Ellsworth McCoy.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May. 27, 1902

(Month)

(Day)

(Year)

7 AGE

28

yrs.

— mos.

6

ds.

or

min.

If LESS than 1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Paper finishes

(b) General nature of industry business, or establishment in which employed or (employer)

Paper mill

9 BIRTHPLACE

(State or country)

Baltimore Md.

10 NAME OF FATHER

Elmer E. McCoy.

11 BIRTHPLACE OF FATHER

(State or country)

York Co. Pa.

12 MAIDEN NAME OF MOTHER

Margaret B. Turbaugh

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Bowser

(Address)

Freeland Rd. RD.

15

Filed

June 4

1930

Samuel S. Miller

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 3

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Oct. 1

1929

to

June 3

1930

that I last saw him alive on

June 3

1930

and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH was as follows:

Chronic Endocarditis (mitral stenosis)

(Duration)

4

yrs.

mos.

da.

Contributory Secondary

(Duration)

yrs.

mos.

da.

(Signed)

R. D. Shantz

M. D.

June 4

1930

(Address)

Shrewsbury Pa.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

da.

In the State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Zion Cemetery, Freeland Rd.

June 5

1930

20 UNDERTAKER

ADDRESS

Hartman's Undertakers, Mt Zion Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meadles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 7 1910  
BUREAU OF

MARGIN RESERVED FOR BINDING

WRITE

LY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County Balto

01402

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 31Village or City Sranits (No. \_\_\_\_\_)

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Harry M. Daniel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
-------------------	---------------------------------	--

6 DATE OF BIRTH

Mar 24, 1929  
(Month) (Day) (Year)

7 AGE

10 yrs. 12 mos. 12 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE

(State or country) Ind

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country) Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Daniel(Address) Woodsboro Ind

15 Filed

2/6 1930 H. F. Shipley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 6, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Feb 5, 1930 to Feb 6, 1930  
that I last saw him alive on Feb 5, 1930,

and that death occurred on the date stated above, at 230 m.  
The CAUSE OF DEATH \* was as follows:
Pertussis(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 21 ds.Contributory  
SecondaryExhaustion(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 4 ds.

(Signed)

Harry F. Shipley M. D.  
Feb 6, 1930 (Address) Woodsboro Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

StaphorsFeb 7, 1930

20 UNDERTAKER

ADDRESS

John M. DanielWoodsboro

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; - . . . . . pneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 4 1930  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

05294

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 40

Village or City

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

May 14, 1936  
(Month) (Day) (Year)

7 AGE

yrs. mos. ds. or min.?  
If LESS than 1 day/0 hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Judith McOmge

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Catherine C. Cottenberg

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

May 15, 1936 J. H. Gussack  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 14, 1936  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from

May 14, 1936 to May 14, 1936

that I last saw her alive on May 14, 1936

and that death occurred on the date stated above, at 9:10 p.m.

The CAUSE OF DEATH \* was as follows:

Premature birth

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. H. Gussack M. D.

May 15, 1936 (Address) Baltimore

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elder Farm Hyde Md

May 16, 1936

20 UNDERTAKER

ADDRESS

Clarence E. Arthur

Frodo Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Postman*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telum*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1930

WRITE

ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Catonsville Md

2 FULL NAME John McEvoy

0196 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH October 18, 1854  
(Month) (Day) (Year)

7 AGE 75 yrs. 2 mos. 1 ds. or LESS than 1 day     hrs.     min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) Funeral

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Patrick McEvoy

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mollie Haunigau

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Daughter (Informant) Mrs J. C. Logue  
(Address) 1715 E 29th

15 Filed Jan 20 1930 C. L. Mattfeldt  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 2, 1929 to Jan 19, 1930  
that I last saw him alive on Jan 19, 1930

and that death occurred on the date stated above, at 12:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral hemorrhage  
(Duration) 1 yrs.     mos.     ds.

Contributory arterio sclerosis  
Secondary (Duration) 2 yrs.     mos.     ds.

(Signed) John G. Kunkel M. D.  
Jan 19, 1930 (Address) Catonsville Md

\*State the 1 is cause Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 17 mos.     ds. In the State     yrs.     mos.     ds.

Where was disease contracted, if not at place of death?

Former or usual residence 921 E. 7th St. N.

19 PLACE OF BURIAL OR REMOVAL New Cathedral DATE OF BURIAL Jan 22, 1930

20 UNDERTAKER Rita Winfield ADDRESS 914 Greenmount Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

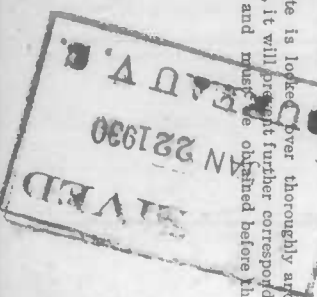
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archibald, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Dysentery* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is permanently filed.



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore02652 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. 115 Melvin Avenue St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Neal Laurence McFee

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH  
January 16, 1930  
(Month) (Day) (Year)7 AGE  
2 yrs. 4 mos. 4 ds. or        min.?  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)       9 BIRTHPLACE  
(State or country) Maryland10 NAME OF FATHER George C. McFee11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Patricia LeGourd13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George C. McFee,(Address) 115 Melvin Ave. Catonsville15 Filed 3/21 1930 Alfred Registrar

If more blanks are needed, procure from Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 20, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Mar. 20, 1930 to Mar. 20, 1930,that I last saw him alive on Mar. 20, 1930,and that death occurred on the date stated above, at 9:00 P.m.

The CAUSE OF DEATH \* was as follows:

Purpura HaemorrhagicaContributory  
Secondary  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 14 ds.(Signed)        M. D.  
Jan. 21 1930 (Address) Catonsville, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?       Former or usual residence       19 PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL Mar. 21, 193020 UNDERTAKER Easton Sons ADDRESS Ellicott City,Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstain, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 3 1930  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		10158		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Randallstown</u>		158-c		Registration Dist. No. <u>91</u>	
2 FULL NAME <u>John Mc Gowan</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>May 10<sup>th</sup> 1858</u> (Month) (Day) (Year)					
7 AGE <u>72</u> yrs. <u>4</u> mos. <u>8</u> ds. or <u>1</u> day <u>hrs.</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>County Roads</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
10 NAME OF FATHER <u>John Mc Gowan</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>					
12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Thomas Baxter</u> (Address) <u>Owings Mills Md</u>					
15 Filed <u>9/19/30</u> 192 <u>7</u> . <u>h. n. 1</u> <u>Butler</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>September 18<sup>th</sup> 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>m.</u> The CAUSE OF DEATH * was as follows: <u>Fractured skull and broken neck resulting from being struck by automobile</u> (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.					
Contributory Secondary (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>Christman M. D.</u> <u>Sep 18 1930</u> (Address) <u>Pikesville</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Holy Family Cem</u>				DATE OF BURIAL <u>Sept 20 1930</u>	
20 UNDERTAKER <u>Mamma Ponton</u>				ADDRESS <u>2738 W North</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

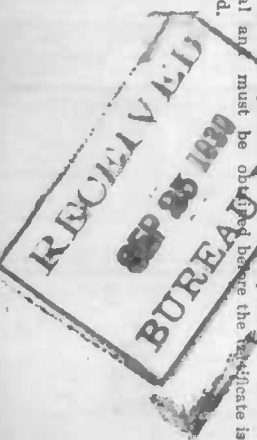
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE

ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Baltimore

04777

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 114Village or City Edgemere (No. Sparrows Point Road St.        Ward       )

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edward B. McGranahan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH Dec. 19, 1860  
(Month) (Day) (Year)7 AGE 68 yrs. 4 mos. 11 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Pa.10 NAME OF FATHER John A. McGranahan11 BIRTHPLACE OF FATHER (State or country) Pa.12 MAIDEN NAME OF MOTHER Harriet Hunter13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mildred Reisinger(Address) Sparrows Point Road15 Filed May 1st 1920 J. McCormick Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 30, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 26th 1930 to April 30th 1930.that I last saw him alive on April 27th 1930.and that death occurred on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH \* was as follows:

Hypertrophy ProstateContributory Secondary Uremic Poisoning  
(Duration) 2 yrs. 7 mos. 7 ds.(Signed) Frank C. Eichel M. D.  
4-30-1930 (Address) Spencer St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sharon Pa DATE OF BURIAL MAY 1, 193020 UNDERTAKER John F. Denny ADDRESS 815 Light St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Broncho pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Baltimore

10159

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Spaw Point (No. 1116, F.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Paul G. McGrath

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept 27, 1904  
(Month) (Day) (Year)

7 AGE

25 yrs. 11 mos. 26 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Clerk at

(b) General nature of industry, business, or establishment in which employed or (employer)

Bethlehem Steel Co.

9 BIRTHPLACE

(State or country)

Pa

10 NAME OF FATHER

P. J. McGrath

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bethlehem Steel Co.

(Address)

Spaw Point Md

15 Filed

Apr 22 1930 G. C. McTear Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 22, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192\_\_ to 192\_\_,

that I last saw him alive on 192\_\_,

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Accidental death Caused by his automobile  
leaving the road and colliding  
with a telephone pole, on Wise Ave. in the 15th. Election Dis-  
trict, Balto. Co., Md. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
SecondaryActing Governor  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

Thomas R. Brannen

M. D.

Sept 22 1930 (Address) R101348 Spaw Point\*State the Disease Causing Death, or, in doubtful cases, Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. None

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sharon PaSept 22 1930

20 UNDERTAKER

ADDRESS

John F. Denny 715 Light St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Laundress*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

OCT 6 1930

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by hydrochloric acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore07153 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 28Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Agnes Mc Ginnis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed6 DATE OF BIRTH December 20, 1868  
(Month) (Day) (Year)7 AGE 61 yrs. 7 moa. 2 ds. or LESS than 1 day.....hrs. min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Ohio10 NAME OF FATHER Thomas Wall11 BIRTHPLACE OF FATHER (State or country) England12 MAIDEN NAME OF MOTHER Ada Lake13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records--Personal History(Informant) Eudowood Sanatorium, Towson, Md.  
(Address)15 Filed June 22, 1930 Wm. P. Butler Registra

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 14, 1930 to June 22, 1930, that I last saw her alive on June 22, 1930, and that death occurred on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH \* was as follows:

Pulmonary tuberculosis  
about (Duration) 13 yrs. mos. ds.Contributory  
Secondary(Signed) W. A. Bridges M. D.  
June 22, 1930 (Address) Towson, Maryland.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 1 mos. 8 ds. In the State 18 yrs. mos. ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence 20 South Ave. Landsdown Md.

19 PLACE OF BURIAL OR REMOVAL

Wm. Co. Mt. Olive DATE OF BURIAL 25, 1930

20 UNDERTAKER

Wm. Cook ADDRESS 1217 St Paul

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

06450

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Sparrows Point

St. 203 E Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Still born infant McKim

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single.

6 DATE OF BIRTH June 10<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. or — min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Harriet McKim

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Bertha E Jones

13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha E McKim

(Address) Sparrows Point

15 Filed June 11 1930 G. W. Lomnick Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 10<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw h. — alive on —, 192

and that death occurred on the date stated above, at 2<sup>10</sup> A m.  
The CAUSE OF DEATH \* was as follows:

Still born  
(Duration) 6 mos yrs. mos. ds.

Contributory  
Secondary

(Signed) G. W. Lomnick M. D.  
June 11, 1930 (Address) Sparrows Point

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bent to Johns Hopkins, 19—

20 UNDERTAKER ADDRESS

Anatomical Laboratory

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 7 1930  
BUREAU V 8



## 1 PLACE OF DEATH

County

Baltimore

04006

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City

Larchmont (No. 2404 Poplar Drive)

St. Ward

(If death occurred in a hospital or institution, give its NAME in full, street and number.)

2 FULL NAME

Joseph B. McLaughlin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

March

19

1930

(Month)

(Day)

(Year)

7 AGE

23

If LESS than

1 day.....hrs.

yrs.

mos.

ds.

or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore Co., Md.

10 NAME OF FATHER

Joseph B. McLaughlin

11 BIRTHPLACE OF FATHER

(State or country)

Baltn., Md.

12 MAIDEN NAME OF MOTHER

Anna Ethel Helms

13 BIRTHPLACE OF MOTHER

(State or Country)

Baltn. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph B. McLaughlin

(Address)

2404 Poplar Drive.

15

Filed

April 12 1930

C. L. Mattfeldt

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April

11

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

March 19

1930

to

April 11

1930

that I last saw him alive on

April 11

1930

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH \* was as follows:

Congenital Syphilis

(Duration)

yrs.

mos.

23

ds.

Contributory Secondary

Malnutrition

(Duration)

yrs.

mos.

23

ds.

(Signed)

Charles C. Conser

M. D.

ap 11

1930

(Address)

401 N. Fulton Ave.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral

April 12, 1930

20 UNDERTAKER

ADDRESS

Joseph B. McLaughlin 1606 W. North Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECORDED  
MAY 5 1938  
BUREAU

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.  
Village or City Mt Washington

10160  
90  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 32

2 FULL NAME Patrick M. Mahon

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Which?) Married

6 DATE OF BIRTH Sept 10 1830  
(Month) (Day) (Year)

7 AGE 93 yrs. — mos. — ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Contractor  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Thomas McMahon

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15 Filed 9/12/1930 X E. E. Ruch do.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 10 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 8 1930 to Sept 10 1930

that I last saw him alive on Sept 10 1930

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:

Senile degeneration. Arterio Sclerosis - Cerebral Regeneration

(Duration) yrs. mos. 14 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) E. H. Beeler M. D.

9. 11 1930 (Address) Mt Washington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Thomas Church

DATE OF BURIAL Sept 13 1930

20 UNDERTAKER AS Marshall ADDRESS 3539 Fall Rd

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Insanition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
OCT 1 1911  
BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			13574		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Pikesville</u> (No. <u>Confed. Soldiers Home</u> )			Registration Dist. No. <u>32</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Cornelius J. Michaux</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>				
6 DATE OF BIRTH <u>unknown</u> , 1 (Month) (Day) (Year)						
7 AGE <u>about 88</u> yrs. (Month) (Day) (Year) (If LESS than 1 day hrs. or min.)						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>New Orleans</u>						
10 NAME OF FATHER <u>Unknown</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>						
12 MAIDEN NAME OF MOTHER <u>Unknown</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Father Broderick</u> (Address) <u>St. Thomas Church 374 St. Michigan Ave</u>						
15 Filed <u>Nov 26</u> 19 <u>30</u> <u>EE Dechols</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>November 25</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>for many months</u> , 19 <u>30</u> . That I last saw him alive on <u>Nov 20</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>70</u> m. The CAUSE OF DEATH * was as follows:						
<u>Popliteal</u> (Duration) yrs. mos. <u>14</u> ds. Contributory <u>Senior Degeneration</u> Secondary <u>Arteriosclerosis</u> (Duration) yrs. mos. ds. (Signed) <u>W. J. O. Nye</u> M. D. <u>Nov 26</u> 19 <u>30</u> (Address) <u>Chesapeake Md</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? <u>Yes</u> Former or usual residence <u>Yes</u>						
19 PLACE OF BURIAL OR REMOVAL <u>New Cathedral</u>					DATE OF BURIAL <u>Nov 27, 1930</u>	
20 UNDERTAKER <u>Chenoweth Son</u>					ADDRESS <u>3415 Chestnut Ave</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only, not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
DEC 4 1930

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1 PLACE OF DEATH			13575 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			Registration Dist. No. <u>30</u>	
Village or City <u>Woodlawn</u> (No. <u>Johnnybake Rd</u> )			St.:	Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Mary E. Meehan</u>				
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>	16 DATE OF DEATH <u>Nov 21</u> , 19 <u>30</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Oct 6</u> , 19 <u>23</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 18</u> , 19 <u>30</u> to <u>Nov 21</u> , 19 <u>30</u> , that I last saw him alive on <u>Nov 21</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>11:50</u> p.m. The CAUSE OF DEATH * was as follows: <u>Cerebral Hemorrhage</u> (Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. Contributory <u>arterio Sclerosis</u> Secondary (Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. (Signed) <u>Marshall B. Woot</u> M. D. <u>Nov 22</u> , 19 <u>30</u> (Address) <u>Catonville Ind</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
7 AGE <u>67</u> yrs. <u>1</u> mos. <u>25</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Md.</u>				
10 NAME OF FATHER <u>George Jones</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>England</u>				
12 MAIDEN NAME OF MOTHER <u>Hannah Deboyd</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>England</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Michael Meehan</u> (Address) <u>Woodlawn Md</u>				
15 Filed <u>11/23/30</u> 19 <u>30</u> <u>Alfreda</u> Registrar <u>Deputy</u>				
19 PLACE OF BURIAL OR REMOVAL <u>Bonnie Brae</u>			DATE OF BURIAL <u>Nov 24</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Philip Skwig</u>			ADDRESS <u>2016 Orleans St</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930

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1 PLACE OF DEATH  
County Baltimore

Village or City Randalltown

2 FULL NAME Mary Elizabeth Treckus

12864 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 31

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH June 21, 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 3 mos. 18 ds. or min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work H. Tr.  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Wd.

10 NAME OF FATHER Thos. Cornthwaigh

11 BIRTHPLACE OF FATHER (State or country) Wd. Griffith

12 MAIDEN NAME OF MOTHER Griffith

13 BIRTHPLACE OF MOTHER (State or country) Wd.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. Snyder

(Address) Randalltown

15 Filed 10/10/30 M. N. Buppert Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 25, 1930 to Oct 9, 1930, that I last saw her alive on Oct 9, 1930, and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH \* was as follows:

Ch. Int. nephritis

(Duration) 1 yrs. 2 mos. 1 ds.

Contributory Secondary

(Signed) Wm. E. Martin M. D.  
10-8-1930 (Address) Randalltown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Clare Cemetery Oct. 11, 1930

20 UNDERTAKER

ADDRESS

W. E. & Son Sykesville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

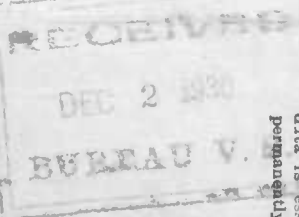
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		12210		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Balto</u>		(168)		Registration Dist. No. <u>43</u>	
Village or City <u>Remond Pk</u> (No. <u>East</u> )		St. <u>MEINERS</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Henry Meiners</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>	16 DATE OF DEATH <u>Oct. 20th</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Nov. 28</u> , 19 <u>90</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>dead</u> 19 <u>2</u> to <u>10/20/30</u> , 19 <u>2</u> , that I last saw him alive on <u>10/20/30</u> , 19 <u>2</u> , and that death occurred on the date stated above, at <u>m</u> . The CAUSE OF DEATH * was as follows: <u>(Strangulation)</u> <u>suicidal hanging</u> <u>with a Transon belt</u> (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		
7 AGE <u>39</u> yrs. <u>10</u> mos. <u>22</u> ds. or <u>      </u> min?			Contributory Secondary (Duration) <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Freight</u>			(Signed) <u>Sustine A. Fritz</u> M. D. <u>10/20/30</u> 19 <u>2</u> (Address) <u>8 Conlan</u>		
9 BIRTHPLACE (State or country) <u>Balto</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.		
PARENTS	10 NAME OF FATHER <u>Henry C. Meiners</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Bermdy</u>		Where was disease contracted, if not at place of death? <u>      </u>		
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Field</u>		Former or usual residence <u>      </u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Bermdy</u>		19 PLACE OF BURIAL OR REMOVAL <u>Oak Lawn Cemetery</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>D. Elizabeth Meiners</u> (Address) <u>      </u>			DATE OF BURIAL <u>Oct 22, 1930</u>		
15 Filed <u>10/21</u> , 19 <u>30</u> <u>G. A. Fritz</u> Registrar			20 UNDERTAKER <u>Frank Casanova</u>		
			ADDRESS <u>7401 Selwin Rd.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebro spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Coriaria, Sorcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
NOV 4 1930  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		05296		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Spencer Point, Md</u>		(89)		Registration Dist. No. <u>44</u>	
2 FULL NAME <u>John A. Menton</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>June 3</u> , 1871 (Month) (Day) (Year)		16 DATE OF DEATH <u>May 19</u> , 19 <u>30</u> (Month) (Day) (Year)			
7 AGE <u>58</u> yrs. <u>11</u> mos. <u>14</u> ds. or min.?		17 I HEREBY CERTIFY, That I attended the deceased from <u>the time of death</u> to <u>the time I last saw him alive</u> , on <u>May 19</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9:15</u> a.m. The CAUSE OF DEATH * was as follows: <u>Coronary Thrombosis</u> <u>Chronic</u>			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Foreman</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Bethlehem Steel Co</u>		Contributory Secondary (Duration) yrs. mos. ds.			
9 BIRTHPLACE (State or country) <u>Delaware</u>		(Signed) <u>Wm. M. Nichols</u> Board <u>June 19, 1930</u> (Address) <u>Spencer Point</u>			
PARENTS	10 NAME OF FATHER <u>Denis J. Menton</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
	11 BIRTHPLACE OF FATHER (State or country) <u>do not know</u>	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.			
	12 MAIDEN NAME OF MOTHER <u>do not know</u>	Where was disease contracted, if not at place of death? Former or usual residence			
13 BIRTHPLACE OF MOTHER (State or Country) <u>do not know</u>	19 PLACE OF BURIAL OR REMOVAL <u>New Cathedral</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John A. Menton</u> (Address) <u>3313 Fort Ave</u>		20 UNDERTAKER <u>John A. Moran</u>		DATE OF BURIAL <u>May 22, 1930</u>	
15 Filed <u>May 19</u> , 192 <u>30</u>	<u>G. H. McCormick</u> Registrar		ADDRESS <u>300 E. Balto. St.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrubman, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Co. 1206 63<sup>rd</sup> ST., ..... WARD)

## 2. FULL NAME

Rudolph Mergle

## (a) RESIDENCE No.

1206 63<sup>rd</sup>

ST., ..... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

## REGISTERED NO.

44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Blanche L. Mergle6 DATE OF BIRTH (month, day, and year) May 30<sup>th</sup> 19037 AGE Years Months Days If LESS than 1 day, .... hrs. or .... min.  
27 4 4

## OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

Electric

(c) Name of employer

Gas & Electric Co

9 BIRTHPLACE (city or town) (State or country)

Bohemia10 NAME OF FATHER Joseph Mergle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia12 MAIDEN NAME OF MOTHER Sophie Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia14 Informant Blanche L. Mergle (Address) 1206 63<sup>rd</sup> St15 Filed ..... 19 1930 Registrar RPEK

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4<sup>th</sup> 193017 I HEREBY CERTIFY That I attended deceased from June 1<sup>st</sup> 1930 to Oct 4<sup>th</sup> 1930that I last saw him alive on Oct 4<sup>th</sup> 1930and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Stomach(duration) 7 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

Chronic IndigestionApoplexy (duration) .... yrs. .... mos. .... ds.18 Where was disease contracted Unknown  
If not at place of death?Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Dr. J. H. Jones, M. D.Oct 1930 (Address) 3307 Chatterbox St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery 10/7/1930

20 UNDERTAKER

ADDRESS

Wm Cook 1217 St Paul St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact element of OCCUPATION is very important. See instructions on back of certificates.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assoc.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name ori-

gin "Cancer" is less definite). Avoid use of "Tumor" for malignant neoplasms, *Measles*; *Whooping cough*, *chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City Louley (No. \_\_\_\_\_)

2 FULL NAME Carl H. Merkel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb. 17, 1 886  
(Month) (Day) (Year)

7 AGE 74 yrs. 8 mos. 9 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Attending to  
(b) General nature of industry, business, or establishment in which employed or (employer) his own lawn

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Nithelm Merkel

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida M. Merkel  
(Address) Louley Md.

15 Filed Oct. 27 1930 J. F. H. Kusch  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug. 10 1930 to Oct. 26 1930

that I last saw him alive on Aug. 10, 1930,

and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH \* was as follows:

Cerebral hemorrhage

(Duration) 3 yrs. 3 mos. 3 ds.  
Contributory Chronic valvular heart disease  
Secondary

(Duration) 2 yrs. 3 mos. 3 ds.  
(Signed) Walter H. Smith M. D.  
10/28 1930 Address Baltimore

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Torden Park Cem. DATE OF BURIAL Oct. 28 1930

20 UNDERTAKER Clarence E. Arthur ADDRESS North Md.

12, 30

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1890

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		02657 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Grants</u> (No. _____)		Registration Dist. No. <u>31</u>	
2 FULL NAME <u>Joseph B. Munkle</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>My</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Apr 26</u> 192 <u>7</u> (Month) (Day) (Year)			
7 AGE <u>2</u> yrs. <u>11</u> mos. <u>4</u> ds. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Ind</u>			
10 NAME OF FATHER <u>Anthony W. Munkle</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>			
12 MAIDEN NAME OF MOTHER <u>Blanchy Grant</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Raymond Munkle</u> (Address) <u>Grants Ind</u>			
15 Filed <u>3/30</u> 19 <u>30</u> <u>H. F. Shipley</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Mar 30</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Mar 27</u> 19 <u>30</u> to <u>Mar 30</u> , 19 <u>30</u> that I last saw him alive on <u>Mar 30</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>39</u> m. The CAUSE OF DEATH * was as follows: <u>Broncho Pneumonia</u> (Duration) _____ yrs. _____ mos. <u>3</u> ds. Contributory <u>Pertussis</u> Secondary _____ (Duration) _____ yrs. <u>1</u> mos. _____ ds. (Signed) <u>Harry F. Shipley</u> M. D. <u>3/30</u> 19 <u>30</u> (Address) <u>Woodlawn Ind</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Prushy Cemetery</u>		DATE OF BURIAL <u>Mar 31</u> 19 <u>30</u>	
20 UNDERTAKER <u>Wm. &amp; Son</u>		ADDRESS <u>Lykens Ind</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Form laborer, Loborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Scarlatina pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 8 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

07720

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(129)

Registration Dist. No. 42Village or City Calutia (No. \_\_\_\_\_)Benson Ave St.

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Wilhelmine J. S. Merson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH <u>April 13, 1890</u> (Month) (Day) (Year)
--

7 AGE <u>30 yrs. 3 mos. 3 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
--------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)
--

9 BIRTHPLACE (State or country) <u>Baltimore Co.</u>
---

10 NAME OF FATHER <u>William H. Brueger</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>
--

12 MAIDEN NAME OF MOTHER <u>Caroline Summerfield</u>
---

13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H. Brueger(Address) Calutia Md15 Filed July 6, 1930 B. G. Hoffmeyer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Apr 10, 1929 to July 16, 1930, that I last saw him alive on July 14, 1930, and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:

Cerebral HemorrhageContributory Secondary Chronic Hypertension (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) James H. Kugler, M. D. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
1930 (Address) 1729 N. Lomb St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

London Pr. Cem

DATE OF BURIAL

July 19, 1930

20 UNDERTAKER

Mrs. E. Miller Son

ADDRESS

2334 Jefferson St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU OF VITALS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Middle River (No. Bird River Road)

2 FULL NAME Elizabeth Messenger

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Jan 16 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 10 mos. 13 ds. If LESS than 1 day \_\_\_ hrs. or \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Reider

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Messenger  
(Address) Middle River Md.

15 Filed Dec 1 1920 John G. Comely  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 29, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 3 1920 to Nov 29, 1920, that I last saw him alive on Nov 28, 1920.

and that death occurred on the date stated above, at 7:30 a m.  
THE CAUSE OF DEATH \* was as follows:

Chronic Myocarditis and Arteriosclerosis  
(Duration) 2 yrs. \_\_\_ mos. \_\_\_ ds.

Contributory  
Secondary

(Signed) C. Wallace M. D.  
Dec 1 1920 (Address) Rossville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ebenezer Cemetery DATE OF BURIAL Dec 2, 1920

20 UNDERTAKER Frank G. G. G. G. G. ADDRESS 7401 Adelphi Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU

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1 PLACE OF DEATH

County

*Balto.*

10165

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *022*Village or City *Pikesville* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*William Emanuel Messersmith*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Divorced*

6 DATE OF BIRTH

*Aug. 28, 1865*  
(Month) (Day) (Year)

7 AGE

*65 yrs. 1 mos. 8 ds.*  
If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Butcher*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)*Maryland*10 NAME OF  
FATHER*William Messersmith*11 BIRTHPLACE  
OF FATHER  
(State or country)*Maryland*12 MAIDEN NAME  
OF MOTHER*Amin Hoben*13 BIRTHPLACE  
OF MOTHER  
(State or Country)*Ireland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*J. D. Messersmith*

(Address)

*Pikesville, Md.*

15

Filed

*9/28/1920*

192

*E. C. Chace*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*September 28, 1920*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*September 1920 to Sept 28, 1920*

that I last saw him alive on \_\_\_\_\_, 1920

and that death occurred on the date stated above, at *11:2 A.M.*

The CAUSE OF DEATH \* was as follows:

*Cerebral Hemorrhage*

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary*Cerebral Vascular Mal*(Duration) *3* yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) *Palmer F. L. Williams* M. D.*Sept 28, 1920* (Address) *Pikesville, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery Sept 30, 1920*

20 UNDERTAKER

ADDRESS

*Chas. H. Brown Ave 118 W. Mt. Royal*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia, infection, peritonitis, etc.*" State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

1822, 1823, 1824, 1825.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto.</u>		0199 (742)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Colegate</u> (No. <u>Monumental &amp; Trappe Rds</u> )		St.: _____		Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Charles Meyers Jr.</u>		Registration Dist. No. <u>4</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Sept 15/1872</u> (Month) (Day) (Year)					
7 AGE <u>56</u> yrs. <u>3</u> mos. <u>25</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Store Keeper</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Himself</u>					
9 BIRTHPLACE (State or country) <u>Balto Md</u>					
PARENTS	10 NAME OF FATHER <u>Chas Meyers</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Wilhelmina Schroeder</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Catherine O'Connor</u> (Address) <u>103 S. East Ave</u>					
15 Filed <u>1/10/30</u> 192 <u>Dr. McCarroll</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 10</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at <u>6:01</u> a.m. The CAUSE OF DEATH * was as follows: <u>Apoplexy</u> <u>Dr. Walter Carmin</u> (Duration) yrs. mos. ds. Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>Frederick Williams Coroner</u> M. D. 192 (Address)					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Cath. Lawn</u>				DATE OF BURIAL <u>Jan 13, 1930</u>	
20 UNDERTAKER <u>Philips Herwig</u>				ADDRESS <u>2016 Orleans St</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart-failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent much correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

005183 NY  
DEATH

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated. ACTUALLY LIVED. Exact CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore  
Sheppard and Enoch Pratt Hospital

Village or City TOWSON (No. \_\_\_\_\_)

05297  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 38

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Thomas F. Meyers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~SINGLE~~ MARRIED  
~~MARRIED~~  
~~OR DIVORCED~~  
 (Write the word)

6 DATE OF BIRTH Aug. 18, 1879  
 (Month) (Day) (Year)

7 AGE 50 yrs. 9 mos. 7 ds. or min.?  
 IF LESS than 1 day hrs.

8 OCCUPATION  
 (a) Trade, profession or particular kind of work Bookkeeper  
 (b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto. Md.

10 NAME OF FATHER Chas. F. Meyers

11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna B. Adler

13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) \_\_\_\_\_

15 Filed May 23 1930 H. E. P. Burk Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25, 1930  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 14, 1930 to May 25, 1930, that I last saw him alive on May 24, 1930 and that death occurred on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH \* was as follows:

Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.  
 Contributory Arteriosclerosis  
 Secondary

(Signed) Arthur E. Pattrell, M. D.  
 192\_\_\_\_ (Address) Towson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 11 ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL May 27, 1930

20 UNDERTAKER Ger. W. Little ADDRESS Edmondson

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

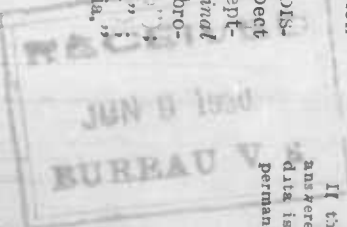
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A litho dia is essential and must be obtained before the certificate is permanently filed.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			07721 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			Registration Dist. No. <u>32</u>	
Village or City <u>Pikesville</u> (No. <u>1</u> ) <u>Linden Terrace</u> St.			Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Elizabeth A. Michard</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widow</u> (Write the word)		
6 DATE OF BIRTH <u>Oct 27</u> <u>1850</u> (Month) (Day) (Year)				
7 AGE <u>79</u> yrs. <u>8</u> mos. <u>13</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Nothing</u> (b) General nature of industry business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Maryland -</u>				
10 NAME OF FATHER <u>Rowan Mayes</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland -</u>				
12 MAIDEN NAME OF MOTHER <u>Margaret A Mayes</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind -</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Miss Munn &amp; Michard</u>				
(Address) <u>#1 Linden Terrace</u>				
15 Filed <u>July 10</u> 192 <u>30</u> <u>E. E. Nichols</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 10</u> 192 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Several months</u> to <u>July 10</u> 192 <u>30</u> that I last saw her alive on <u>July 10</u> 192 <u>30</u> and that death occurred on the date stated above, at <u>1:15 P. M.</u> The CAUSE OF DEATH * was as follows: <u>Tuberculosis</u>				
Contributory (Duration) yrs. mos. ds. <u>Chronic myocarditis &amp; nephritis</u>				
Secondary (Duration) ? yrs. mos. ds. <u>E. E. Nichols</u>				
(Signed) <u>July 10</u> 192 <u>30</u> (Address) <u>Pikesville Md.</u> M. D.				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)				
At place of death yrs. mos. ds. In the State yrs. mos. ds.				
Where was disease contracted, if not at place of death?				
Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL				
<u>Jonas Cemetery, Catonsville</u> <u>July 11, 1930</u>				
20 UNDERTAKER ADDRESS				
<u>Wm. C. Brooks &amp; Son</u> <u>Sparks, Md.</u>				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

AUG 2 1920

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

Village or City Colgate (No. 505 South 46th Street St.        Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elizabeth Mihaila.

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH not known, 1898  
(Month) (Day) (Year)

7 AGE 32 yrs.        mos.        ds. If LESS than 1 day        hrs. or        min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Romania

10 NAME OF FATHER George Coman.

11 BIRTHPLACE OF FATHER (State or country) Romania

12 MAIDEN NAME OF MOTHER Mary Modorcea

13 BIRTHPLACE OF MOTHER (State or Country) Romania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Mihaila  
(Address) 505 S. 46th St. Colgate Md.

15 Filed Oct. 13 1930 John J. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 10th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw h        alive on 192

and that death occurred on the date stated above, at        m.

The CAUSE OF DEATH \* was as follows:

Apoplexy.

Dr. Adam A. Tod.

Balto. Md. (Duration)        yrs.        mos.        ds.

Contributory Secondary (Duration)        yrs.        mos.        ds.

(Signed) Frank H. Adams, CORONER M. D.  
10/10/30 (Address) Dundalk, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Oct. 13, 1930

20 UNDERTAKER John J. Connolly ADDRESS Essex Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. 1-0-1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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NOV 6 1930

BUREAU V. S.

## PARENTS

2FULL NAME

129

## Registration Dist. No. 33

## MEDICAL CERTIFICATE OF DEATH

15 Filed Sub 10 1980 Wickham  
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

me/



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 5 1931

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Parkston (No. \_\_\_\_\_)

2 FULL NAME Clara M. C. Miller

06454 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug. 26, 1867  
(Month) (Day) (Year)

7 AGE 69 yrs. 9 mo. 7 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at Home  
(b) General nature of industry, business, or establishment in which employed or (employer) at Home

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James McCullagh

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Hanyukiewicz

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James C. Miller  
(Address) Parkston R. F. D.

15 Filed June 20, 1930 M. Bortin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 19, 1930 to June 19, 1930  
that I last saw her alive on June 19, 1930,

and that death occurred on the date stated above, at \_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Diabetes Melitus

(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) William Bortin M. D.

June 20, 1930 (Address) White Hall Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Riseburg Cemetery June 21, 1930

20 UNDERTAKER ADDRESS

John Burns Sons Poussard Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples; *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mescalies; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mescalies* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 7 1910

WORK

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## 1 PLACE OF DEATH

County

*Baltimore*

10166

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

35

Village or City

*White Hall, Md.*

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Cortland Landora Miller*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Married*

6 DATE OF BIRTH

*Feb 27, 1957*  
(Month) (Day) (Year)

7 AGE

*73 yrs. 6 mos. 21 ds.* or min.?If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Retired Painter - Paper*

(b) General nature of industry, business, or establishment in which employed or (employer)

*Stanger*

9 BIRTHPLACE

(State or country)

*Pennsylvania*

10 NAME OF FATHER

*Enos Miller*

11 BIRTHPLACE OF FATHER

(State or country)

*Pennsylvania*

12 MAIDEN NAME OF MOTHER

*Abbie Bassett*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Pennsylvania*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Martha E. Miller*

(Address)

*White Hall, Md.*

15 Filed

*Sept 18 1930 M. Baltimore Md.*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Sept 18, 1930*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Aug 26, 1930 to Sept 18, 1930*  
that I last saw him alive on *Sept 17, 1930*and that death occurred on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH \* was as follows:

*Chr. endocarditis  
Mitral regurgitation*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *Paul D. Shant* M. D.*Sept 18, 1930* (Address) *Shrewsbury Pa.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*West Liberty**Sept 20, 1930*

20 UNDERTAKER

ADDRESS

*P. M. Martinsen**White Hall, Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmist (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 1930

BUREAU



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1 PLACE OF DEATH County <u>Baltimore</u>			01406 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Catonsville</u> (No. <u>107 Southwood Ave.</u> Ward <u>6</u> )			Registration Dist. No. <u>30</u>		
2 FULL NAME <u>Guy Fenton Miller</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)	16 DATE OF DEATH <u>Feb. 25, 1930</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Oct. 26, 1897</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the data stated above, at <u>5:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Gas. accidental</u>		
7 AGE <u>32</u> yrs. <u>3</u> mos. <u>30</u> ds. or LESS than 1 day hrs. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Printer</u> (b) General nature of industry business, or establishment in which employed or employer					
9 BIRTHPLACE (State or country) <u>Florida</u>			Contributory Secondary (Duration) yrs. mos. ds.		
PARENTS	10 NAME OF FATHER <u>James M. Miller</u>		(Signed) <u>W. C. Hughes</u> M.D.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		192 (Address) <u>Forums</u>		
	12 MAIDEN NAME OF MOTHER <u>Helene Evans</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Florida</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			At place of death yrs. mos. ds. In the State yrs. mos. ds.		
(Informant) <u>Mrs. Margaret Barner Miller</u>			Where was disease contracted, if not at place of death?		
(Address) <u>Catonsville, Md.</u>			Former or usual residence		
15 Filed <u>7/25</u> 1930 <u>Blindman</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Radford Va.</u> DATE OF BURIAL <u>Feb. 28, 1930</u>		
			20 UNDERTAKER <u>Edson Sons</u> ADDRESS <u>Ellicott City</u>		

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iranition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 8 1930  
BUREAU

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1 PLACE OF DEATH			02658 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			Registration Dist. No. <u>38</u>	
Village or City <u>Anneslie</u> (No. <u>501</u> )			Ward <u>Murdock road</u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Henry M Miller</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>March 16</u> 18 <u>67</u> (Month) (Day) (Year)				
7 AGE <u>63</u> yrs. — <u>4</u> mos. — <u>7</u> ds. or min. If LESS than 1 day hrs.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Brick Layer</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>Contractor</u>				
9 BIRTHPLACE (State or country) <u>Martinsburg W. Va</u>				
PARENTS	10 NAME OF FATHER <u>Joseph M Miller</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore</u>			
	12 MAIDEN NAME OF MOTHER <u>Charlotte Wirtz</u>			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Baltimore</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Mary M Miller</u> (Address) <u>501 Murdock road</u>				
15 Filed <u>March 20</u> 19 <u>80</u> <u>RWP. Outter</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>March 20</u> 19 <u>80</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>DEC-2-</u> 192 <u>9</u> . to <u>March 20</u> 19 <u>80</u> that I last saw him alive on <u>March 20</u> 19 <u>80</u> and that death occurred on the date stated above, at <u>3:02</u> p.m. The CAUSE OF DEATH * was as follows: <u>Atherosclerosis</u>				
(Duration) <u>1</u> yrs. — <u>1</u> mos. — <u>1</u> ds. Contributory <u>Cerebral Hemorrhage +</u> Secondary <u>Cerebral (apoplexy)</u> (Signed) <u>Frank B. Crane</u> M. D. (Address) <u>125 S. Broadway</u> 192 <u>9</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. — <u>1</u> mos. — <u>1</u> ds. In the State <u>1</u> yrs. — <u>1</u> mos. — <u>1</u> ds. Where was disease contracted, if not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Druid Ridge</u>			DATE OF BURIAL <u>Mar 22</u> 19 <u>80</u>	
20 UNDERTAKER <u>John W. Smith</u>			ADDRESS <u>2008 Hillman</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

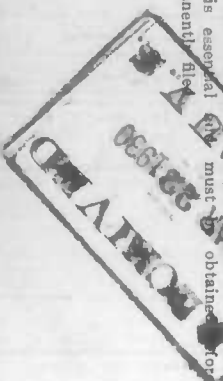
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Ridderwood (No. \_\_\_\_\_)

2 FULL NAME Mary Anna Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, widow, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug. 7, 1886  
(Month) (Day) (Year)

7 AGE 99 yrs. 15 mos. 15 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer) At Home

9 BIRTHPLACE (State or country) Prussia

10 NAME OF FATHER John H. Holby

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Est. Hansen

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Miller  
(Address) Ridderwood

15 Filed Dec 23, 1930 Wm. P. Butler  
Registrar

14712

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 3

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 22, 1930 to Dec 22, 1930, that I last saw him alive on Dec 22, 1930, 192\_\_.

and that death occurred on the date stated above, at 4 P. m.  
The CAUSE OF DEATH \* was as follows:

Senility age had insens  
Senility + heart met form  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary age senility  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. R. Benson M. D.  
Dec 23, 1930 (Address) 6010 York Rd Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Salem B. Bur. DATE OF BURIAL Dec 24, 1930

20 UNDERTAKER John Benson Sons ADDRESS Towson



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Creap"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

02639

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Grays (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Nora C. Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Mar. 16, 1869  
(Month) (Day) (Year)

7 AGE 61 yrs. 11 mos. 10 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John T. Brown

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 M maiden NAME OF MOTHER Alberta Stiltz

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H. Miller

(Address) Ellis City, Md.

15 Filed 3/27 1930 Alfred Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 1, 1926 to March 26, 1926

that I last saw him alive on March 25, 1926

and that death occurred on the date stated above, at 3 A m.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Liver  
(Duration) \_\_\_\_ yrs. 3 mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) J. J. Danneberg M. D.  
Mar. 27, 1926 (Address) Ellis City, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. John's Cem. DATE OF BURIAL Mar. 28, 1930

20 UNDERTAKER Easton Sons ADDRESS Ellis City

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 8 1910

BUREAU

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH. (444)

1-PLACE OF DEATH

Larchmont

REGISTERED NO. 30

CITY OF BALTIMORE: (No. 2708 Surgeon St. WARD)

2-FULL NAME

Catherine Olivia Mills

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 2708 Surgeon St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Wife of Wm J. Mills

6 DATE OF BIRTH (month, day, and year)

Oct 24-1856

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.

74

2

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Nurse

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Charles County  
Maryland

10 NAME OF FATHER

Frank Reed Mills

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Charles County - Md.

12 MAIDEN NAME OF MOTHER -

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

14

Informant  
(Address)Frank Mills - son  
2708 Surgeon St. Ave

15

Filed

26 196 HANSEN JONES, H. B.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

12/25 1930

17

I HEREBY CERTIFY, That I attended deceased from

Nov., 1929, to Dec 25, 1930.

that I last saw him alive on Dec 24, 1930

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Tumor stomach (Ca.?)

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY  
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted  
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) F. A. Squire, M. D.

19 (Address) Med. Arts Bldg.

\*State the Disease Causing Death, or in deaths from Violent Causes,  
state (1) Means and Nature of Injury, and (2) whether Accidental,  
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-  
MOVAL

DATE OF BURIAL

Cathedral Cemetery 12/29 1930

20 UNDERTAKER

ADDRESS

Henry W. Mears and Son 805 N. Calvert

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY SENT TO LOCAL REGISTRAR No. 30 DATE 2/27/31

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

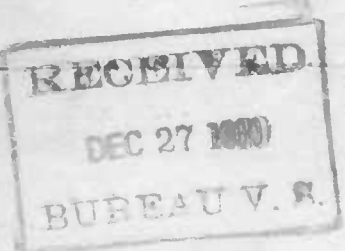
**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of.....(name origin;

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

06495

(188-C)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Sparrows Point (No. 505-6 Street)

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dawson Olin Mills,

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, Single  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH June 8, 1904  
(Month) (Day) (Year)

7 AGE 26 yrs. 20 ds. or min.? If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work School  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Little Rock, Ark.

10 NAME OF FATHER James E. Mills

11 BIRTHPLACE OF FATHER (State or country) Little Rock, Ark.

12 MAIDEN NAME OF MOTHER Mattie J. Clay

13 BIRTHPLACE OF MOTHER (State or Country) Little Rock, Ark.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B.C. Mills

(Address) 505 "C" Street

15 Filed 6/30/30 William Cook Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from investigated and that  
that I last saw him alive on June 29, 1930.

and that death occurred on the date stated above, at 2:15 a.m.  
The CAUSE OF DEATH \* was as follows:

Accidentally

Fractured Skull: Caused by an automobile in which he was riding, turning over, throwing him out on his head. (Duration) 1 hr. mos. ds.

Contributory  
Secondary

(Signed) Jas. M. Nicholas M.D. (Duration) yrs. mos. ds.  
6/30/30 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Little Rock, Arkansas DATE OF BURIAL 7/1, 1930

20 UNDERTAKER William Cook ADDRESS 147 S. Paul Street

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

08987

## CERTIFICATE OF DEATH (129)

## 1—PLACE OF DEATH

Co. CITY OF BALTIMORE: (No. 6504 Beech An ST., WARD)

REGISTERED NO. 43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Mary Helena Minnemann

## (a) RESIDENCE NO.

6504 Beech An ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard S. W. Minnemann

6 DATE OF BIRTH (month, day, and year) Feb 23-1857

7 AGE Years 73 Months 6 Days 6 If LESS than 1 day, hrs. or min.

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER Henry Stein

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Helena Hamel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Leona Gephhardt Wright (Address) 6504 Beech An

15 Filed 8/31, 1930 G. A. Fritz MD Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1930, to Aug 29, 1930 that I last saw him alive on Aug 29, 1930 and that death occurred, on the date stated above, at 8-12 m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage 5 day Necrosis 4 day

CONTRIBUTORY (duration) yrs. mos. ds. Ch. Dilated Nephritis (Secondary) (duration) yrs. mos. ds. 8

18 Where was disease contracted ✓ if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary &amp; Spinal

Signed) Thos Pa Stearns M. D. 8/30/30 (Address) 2878 Hayford St

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL DATE OF BURIAL

London Park 9/1 1930

20 UNDERTAKER ADDRESS

Wilhelm Oak 12745 Paul St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

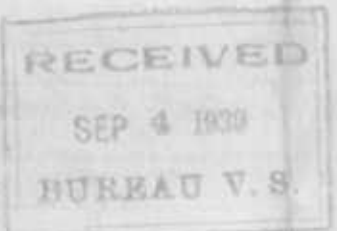
[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm Laborer, Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As themia," "Anemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore
 14713  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH
Registration Dist. No. 38Village or City EUDOWOOD SANATORIUM, TOWSON, MD.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Norothy Louise Mier

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX F. 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

July 31 1912  
 (Month) (Day) (Year)

7 AGE

18 yrs. 4 mos.  ds. or  min.?  
 IF LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Shop Clerk

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Baltimore

10 NAME OF FATHER

Charles L. Mier

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Francis Newberry

13 BIRTHPLACE OF MOTHER (State or Country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 Hospital Records--Personal History,  
 (Informant)  
Eudowood Sanatorium, Towson, Md.  
 (Address)

15

Filed Dec 1 19301930Wm P. Butler

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 1 1930  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from  
October 6 1930 to December 1, 1930
that I last saw her alive on December 1, 1930.and that death occurred on the date stated above, at 6:52 a.m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis(Duration) 7 yrs.  mos.  ds.Contributory  
Secondary(Duration)  yrs.  mos.  ds.(Signed) W. G. Bridges M. D.1930 (Address) Towson, Maryland
 \*State the Disease Causing Death, or, in deaths from  
 Violent Causes, state (1) Means of Injury and (2) Whether  
 Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death 1 yrs. 25 mos.  ds. In the State  yrs.  mos.  ds.
Where was disease contracted, if not at place of death? UnknownFormer or usual residence Baltimore, Md.

19 PLACE OF BURIAL OR REMOVAL

Louisa Park

DATE OF BURIAL

Dec 4 1930

20 UNDERTAKER

Mrs. John H. Seufel & Son

ADDRESS

Bayette 4



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

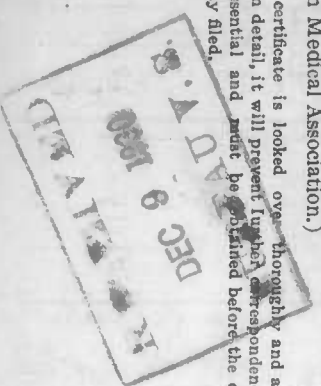
(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—dependent*; *Renovet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balts.

Village or City Essex (No. Margaret Ave. St. Ward)

04009  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jacob Moerschel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Jan. 10th, 1885  
(Month) (Day) (Year)

7 AGE 45 yrs. 7 mos. 24 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Fireman  
(b) General nature of industry, business, or establishment in which employed or (employer) Con. Co. tes.

9 BIRTHPLACE (State or country) Balts. Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (State or Country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mollie Moerschel

(Address) Margaret Ave. Essex

15 Filed Apr. 6 1930 John J. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 3rd, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 2 1930 to Apr. 3 1930, that I last saw him alive on Apr. 3 1930.

and that death occurred on the date stated above, at 12.30 p.m.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) 6 yrs. 6 mos. 6 ds.

Contributory  
Secondary

(Duration) 6 yrs. 6 mos. 6 ds.  
(Signed) James J. Waters M. D.  
Apr 4 1930 (Address) Essex, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Bachmann's Cemetery

DATE OF BURIAL

4/6/1930

20 UNDERTAKER

John J. Connolly

ADDRESS

Essex

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archibut, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1930  
BUREAU OF CENSUS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

Village or City

Spring Grove State Hospital

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

30

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Elise Mouldsdaile

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

white

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

## 6 DATE OF BIRTH

unknown, 1923  
(Month) (Day) (Year)

## 7 AGE

32 yrs. mos. ds. or min.?

If LESS than 1 day hrs. 1 day hrs. 1 day hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

## 9 BIRTHPLACE

(State or country)

Maryland

## 10 NAME OF FATHER

unknown

## 11 BIRTHPLACE OF FATHER

(State or country)

"

## 12 MAIDEN NAME OF MOTHER

Unknown

## 13 BIRTHPLACE OF MOTHER

(State or Country)

"

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ruth Kane (niece)  
Hawze St. Grace Hospital

(Address)

## 15

Filed

94 1930  
30th August  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 6 DATE OF DEATH

August 4th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 14, 1930 to August 4, 1930

that I last saw her alive on August 4, 1930

and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH \* was as follows:

Chronic Bright's Disease

(Duration) 4 yrs. mos. ds.

Contributory Secondary

Parkinson's Disease

(Duration) 8 yrs. mos. ds.

(Signed) Arthur L. Wright M. D.

S. 4, 1930 Address) Catonsville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 2 mos. 21 ds. In the State yrs. mos. ds. life

Where was disease contracted, if not at place of death? Home &amp; Grace

Former or usual residence Catonsville Md

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Calvary Cemetery Aug 6, 1930

## 20 UNDERTAKER

## ADDRESS

Henry Tanning Sons Liberton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as *Asthemia*, *Anaemia* (merely symptomatic), *Atrophy*, "Collapse," *Coma*, "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 10 1931  
BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Shipper

05298 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville No. Harlem Lodge

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles W. Moore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH December 28, 1870  
(Month) (Day) (Year)

7 AGE 59 yrs. 4 mos. 22 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clergyman  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Nathaniel Moore

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Keithley

13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harlem Lodge  
(Address) Catonsville, Md.

15 Filed 5/21 1930 W. Anderson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1930  
(Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 9, 1930 to May 20, 1930.

that I last saw him alive on May 20, 1930.

and that death occurred on the date stated above, at 8:50 p.m.

The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

Contributory (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 de.  
Secondary Depression

(Signed) Samuel Rush Denton, Jr. M. D.  
20 V 1930 (Address) Catonsville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. 3 mos. 11 ds. In the 59 yrs. 4 mos. 2 ds.  
State \_\_\_\_\_

Where was disease contracted, if not at place of death?

Former or usual residence Ridgely Caroline C. Ind.

19 PLACE OF BURIAL OR REMOVAL St. Michaels, Md. DATE OF BURIAL May 22, 1930

20 UNDERTAKER W. J. Dickson & Sons ADDRESS 714 Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds; v. shopteumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

08988

(129)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, that I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory  
Secondary

(Signed)

M. D.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

In the State

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Young"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dakilly" ("Congenital," "Scule," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reckless wound of head—homicide*; *Poisoned by urtic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

Village or City

Halethope

(No.

Ridge - Ave.

St.

Ward)

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

George Wesley Moore

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 SINGLE,

MARRIED,

WIDOWED

OR DIVORCED

(Write the word)

widowed

## 6 DATE OF BIRTH

Sept 4, 1880

(Month)

(Day)

(Year)

## 7 AGE

29 yrs. 9 mos. 5 ds. or min. ?

If LESS than  
1 day....hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work

Clergyman

(b) General nature of industry business, or establishment in which employed or (employer)

Retiree

## 9 BIRTHPLACE

(State or country)

Pa.

## 10 NAME OF FATHER

J. S. Moore

## 11 BIRTHPLACE OF FATHER

(State or country)

Ireland

## 12 MAIDEN NAME OF MOTHER

Boyle

## 13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Story Moore

(Address)

Ridge Ave

## 15

Filed

June 11, 1920 L. M. Matfeen

Registrar

06496

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(49)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 9th, 1920

(Month)

(Day)

(Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

May - 1920, to June 9th, 1920.

that I last saw him alive on June 9th, 1920.

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH was as follows:

Sarcoma - Rt. shoulder

(Duration) 1 yr. 11 mos. 11 ds.

Contributory  
SecondaryMetastases - Acute decomposition  
Heart after physical effort (3 months)

(Signed) Frederick V. Reuter M.D.

June 10, 1920 (Address) Ridge - Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 20 ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Dundon Park

June 12, 1920

## 20 UNDERTAKER

## ADDRESS

Wm. R. Rouse

2238 N. South Ave



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Snyder*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (c) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *epilepsy*, *tetanus*) may be stated under the head of "contributory." (Recommendations on state-ment of cause of death approved by Committee on Nomenclature of the American Medical Association.) If this certificate is looked over thoroughly and all questions answered in detail, it will need no further correspondence. All the data is essential and must be obtained before the certificate is forwarded filed.



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## 1 PLACE OF DEATH

County Baltimore

04010

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Battle Park (No. Sharrow Point Rd. St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME in- stead of street and number.)2 FULL NAME Mary C Moore

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow (Write the word)6 DATE OF BIRTH Feb 26, 1852 (Month) (Day) (Year)7 AGE 78 yrs. 2 mos. 1 ds. or 1 day 1 hrs. or 1 min. IF LESS than8 OCCUPATION (a) Trade, profession or particular kind of work Homemaker (b) General nature of industry, business, or establishment in which employed (or employer) Home9 BIRTHPLACE (State or country) Baltimore Md10 NAME OF FATHER William B Bornemann11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Julia A Callender (Address) Sharrow Pt Rd15 Filed Apr 28 1930 J. W. McMichael Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 27, 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 5th 1930 to April 27th, 1930, that I last saw her alive on April 26th, 1930, and that death occurred on the date stated above, at 1030 a.m. The CAUSE OF DEATH \* was as follows:Carcinoma of liver(Duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary(Signed) Frank C. Edgerly M. D. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Address) Brown Mt

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mt Carmel DATE OF BURIAL April 30 193020 UNDERTAKER John F. Penney ADDRESS 215 Light St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE EARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		STATE OF MARYLAND	
County <u>Baltimore</u>		CERTIFICATE OF DEATH	
Village or City <u>Woodlawn</u> (No <u>Swynn Oak Ave</u> St.: ..... Ward)		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>Mary Elizabeth Moore</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widowed</u> (Write the word)	
6 DATE OF BIRTH <u>Feb. 10, 1861</u> (Month) (Day) (Year)			
7 AGE <u>69</u> yrs. <u>6</u> mos. <u>20</u> ds. or min. ? If LESS than 1 day.... hrs.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed or (employer).....			
9 BIRTHPLACE (State or country) <u>Delaware</u>			
PARENTS			
10 NAME OF FATHER <u>James Harwood</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>			
12 MAIDEN NAME OF MOTHER <u>Mary Moore</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. R. Irwin Moore</u> (Address) <u>2900 Gibbons Ave Balto</u>			
15 Filed <u>Sept 2-30 1930</u> <u>M. N. Buffen</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>August 30, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>Aug 30</u> , 19 <u>30</u> , that I last saw her alive on <u>Aug 29</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>6:45</u> A. m.			
The CAUSE OF DEATH was as follows: <u>Chronic myocardial degeneration with hypertension.</u> (Duration) <u>Chronic</u> yrs. mos. da. Contributory <u>Senility &amp; Apoplexy.</u> Secondary (Duration) <u>Uncertain</u> yrs. mos. da. (Signed) <u>Joshua H. Amacost</u> M. D. <u>Aug. 30, 1930</u> (Address) <u>Woodlawn, Md.</u> *State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death.... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da. Where was disease contracted, if not at place of death? Former or usual residence.....			
19 PLACE OF BURIAL OR REMOVAL <u>Templeville Ind.</u>		DATE OF BURIAL <u>Sept 2, 1930</u>	
20 UNDERTAKER <u>Harry H. Amacost &amp; Son</u>		ADDRESS <u>4204 Ridgewood Ave</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital" "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 4 1900  
BUREAU V. S.



WRITE IN INK ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Carney (No. \_\_\_\_\_)

2 FULL NAME Emma Eugene Moores

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Dec-12, 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 2 mos. 18 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Balto Co Md

10 NAME OF FATHER Dr Lewis Griffith

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Scott

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Malcom Parker

(Address) 23rd Oak Street

15 Filed Apr 30 1923 J. H. Gussack  
Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 40

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 30, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 30, 1923 to April 30, 1923, that I last saw him alive on April 30, 1923, and that death occurred on the date stated above, nt \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Cerebral hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 10 ds.

Contributory Secondary Arteriosclerosis

(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Malcom Parker M. D.  
4/30 1923 (Address) Baltimore

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Lorraine Cemetery DATE OF BURIAL 5/2, 1923

20 UNDERTAKER William Cook ADDRESS 1217 1/2 Paul

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coul mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepey," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City New Rientown (No. MD)

2 FULL NAME Adela Marchhead

12214

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 33

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH Oct 4, 1864 (Month) (Day) (Year)

7 AGE 66 yrs. — mos. 7 ds. or — min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work House work (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) va

10 NAME OF FATHER George Tate

11 BIRTHPLACE OF FATHER (State or country) va

12 MAIDEN NAME OF MOTHER Bessie Evans

13 BIRTHPLACE OF MOTHER (State or Country) va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Blue

(Address) New Rientown Md

15 Filed Oct 13, 1936 H. M. Slade Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 12th, 1936 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 2, 1936 to Oct 12, 1936, that I last saw her alive on Oct 11, 1936,

and that death occurred on the date stated above, at 11 A m. The CAUSE OF DEATH \* was as follows:

Hypertensive Cardiovascular Disease

Contributory (Duration) 2 yrs. — mos. — ds. Secondary Myocardial Decompensation

(Signed) James D. Saffell M. D. (Duration) 10 yrs. — mos. — ds. (Address) New Rientown, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Deer Park Cemetery Oct 14, 1936

20 UNDERTAKER

ADDRESS

J. F. Eoline New Rientown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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NOV 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Hereford (No. \_\_\_\_\_)

2 FULL NAME Mary E. Morfoot

05299 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 39

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME, its street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH January 10, 1 842  
(Month) (Day) (Year)

7 AGE 88 yrs. 3 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Nurse  
(b) General nature of industry, business, or establishment in which employed or (employer) Nurse

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William Morfoot

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Alban

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elijah Hale  
(Address) Hereford Md

15 Filed 578 1930 Francis J. Blake  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1, 1930 to May 8, 1930.

that I last saw him alive on May 7, 1930.

and that death occurred on the date stated above, at 9 h m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) R. W. Shryver M. D.  
May 8, 1930 (Address) Sparks Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Grace Church DATE OF BURIAL May 10, 1930

20 UNDERTAKER Edw. B. Tipton ADDRESS Hampsstead Md

If more blanks are needed, address State Registrar, 13 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ehaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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CITY

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		05300		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Clemont Hills</u> (No. <u>742</u> )		<u>MD</u>		Registration Dist. No. <u>33</u>	
2 FULL NAME <u>M Dorsey Harris</u>		St. <u>      </u> Ward <u>      </u>		(If death occurred in a hospital or institution, give its NAME its extend of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>			
6 DATE OF BIRTH <u>Oct 31, 1860</u> (Month) (Day) (Year)					
7 AGE <u>79 yrs. 7 mos. 30 ds.</u> or <u>      </u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Salesman</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>      </u>					
9 BIRTHPLACE (State or country) <u>Carroll co MD</u>					
10 NAME OF FATHER <u>Nicholas D. Harris</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Carroll co MD</u>					
12 MAIDEN NAME OF MOTHER <u>Caroline Dennis</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Carroll co MD</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lashua G Harvey</u> (Address) <u>Civings Mills MD</u>					
15 Filed <u>May 31 1923</u> <u>25 M. D.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 30, 1923</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Apr. 15, 1923</u> to <u>May 30, 1923</u> , that I last saw him alive on <u>May 24, 1923</u> , and that death occurred on the date stated above, at <u>2 a</u> m. The CAUSE OF DEATH * was as follows: <u>Coronary thrombosis</u> (Duration) <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds. Contributory <u>Arterio-sclerosis</u> Secondary (Duration) <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds. (Signed) <u>J. M. D. Lashua</u> M. D. <u>May 31, 1923</u> (Address) <u>25 M. D.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. Where was disease contracted, if not at place of death? <u>      </u> Former or usual residence <u>      </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Southview Cemetery</u> DATE OF BURIAL <u>June 1<sup>st</sup> 1923</u>					
20 UNDERTAKER <u>J. F. Ehrig</u> ADDRESS <u>Reisterstown MD</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 6 1906

BU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Spessie Point (No. 1301 Buchanan Rd.)

04012 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Morris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Baby  
(Write the word)

6 DATE OF BIRTH April 24 - 1930  
(Month) (Day) (Year)

7 AGE Premature (If LESS than 1 day hrs. 1 day hrs. 2 yrs. mos. ds. or min.?)

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer) infant

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER William J. Morris

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Knight

13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Morris

(Address) 1301 Buchanan Rd

15 Filed Apr. 25 1930 G. H. McCormick Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 24 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Premature infant  
Still-Born  
(Duration) yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) Darwin L. Barber M. D.  
April 25 1930 (Address) Spessie Point Md

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Pirkey Green Co. Ind DATE OF BURIAL April 25, 1930

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 1916  
BUREAU OF VITAL STATISTICS  
U. S. DEPARTMENT OF COMMERCE



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

04013 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Iida Irene Moyley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the words)

6 DATE OF BIRTH Dec. 21, 1899  
(Month) (Day) (Year)

7 AGE 30 yrs. 3 mos. 11 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed or (employer) Nurse-Catonsville State Hosp

9 BIRTHPLACE (State or Country) Pennsylvania

10 NAME OF FATHER John C. Bollinger

11 BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ella Ballblitz

13 BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leo R. Morden

(Address) Catonsville Md.

15 Filed 4/3 1930 W. C. Mendenhall Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from March 29, 1930 to April 1, 1930  
that I last saw her alive on April 1, 1930  
and that death occurred on the date stated above, at 7:35 p.m.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 11 ds.

Contributory Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Marshall B. West M. D.  
April 2, 1930 (Address) Catonsville Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL Apr 4, 1930

20 UNDERTAKER Easton Sons ADDRESS Chesapeake

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

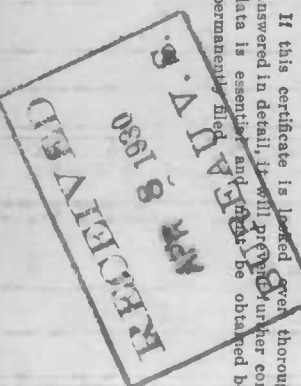
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

161a 01407

## 1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Fuller St. ST.,

WARD)

REGISTERED NO. 43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Mayer(a) RESIDENCE NO. Fuller St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE white5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 2-10-20

7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.8 OCCUPATION OF DECEASED Frederick

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)10 NAME OF FATHER Herbert Mayer11 BIRTHPLACE OF FATHER (city or town)  
(State or country)12 MAIDEN NAME OF MOTHER Eliza Mayer13 BIRTHPLACE OF MOTHER (city or town)  
(State or country)

14

Informant Mr. Mayer  
(Address) Fuller St.

15

Filed 2/19, 1930G. A. Fenty

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-18-20

17

I HEREBY CERTIFY, That I attended deceased from

2-10-20, 1920, to 2-18-20, 1920,that I last saw him alive on 2-15-20, 1920,and that death occurred, on the date stated above, at 1 P.M. m.

The CAUSE OF DEATH\* was as follows:

Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? for this(Signed) Dr. J. B. Bess19 (Address) 2-18-20 800 N. Butler St.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Lacarne Cemetery2/19 1930

20 UNDERTAKER

ADDRESS

Fred Lacarne & SonFuller St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assn.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As theia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City Colgate (No. North Point Road)

2 FULL NAME Frederick Mueller

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 8, 1851  
(Month) (Day) (Year)

7 AGE 79 yrs. 21 ds. or 21 min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Carpenter + Builder  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (State or Country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ottila Mueller

(Address) Colgate, Balto. Co. Md.

15 Filed June 30, 1930 John H. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 21, 1930 to June 29, 1930,

that I last saw him alive on June 28, 1930,

and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 9 ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Robert W. Atkey M. D.  
June 30, 1930 (Address) 100. Patterson Park Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cemetery July 2, 1930

20 UNDERTAKER

ADDRESS

George W. Dinkler 1737 E. Eager St



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired—6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 6 1910  
BUR

WRITE

FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

01408

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 40

Village or City Long Green (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Josephine Stoen Muller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH December 17, 1853  
(Month) (Day) (Year)

7 AGE 76 yrs. 2 mos. 10 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Baltimore Co. Md.

10 NAME OF FATHER Henry Stoen

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Flynn

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Muller

(Address) Long Green Md.

15 Filed Feb. 25 1930 J. A. H. Gussack Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 27, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 30 19230 to Feb 26 19230, that I last saw her alive on Feb 26 19230, and that death occurred on the date stated above, at 7-15 P.M.

The CAUSE OF DEATH \* was as follows:

Carcinoma breast

(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Dr. W. H. Hammett M. D.  
Feb 28 19230 (Address) Baltimore

\*State the 1 is as Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St Johns Catholic Cemetery DATE OF BURIAL March 3<sup>rd</sup> 1930

20 UNDERTAKER John E. Slade ADDRESS Long Green Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAR 5 1930  
BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto Co

Village or City Woodlawn

2 FULL NAME Richard Mullineaux

08490 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 3

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Jan 14 1855  
(Month) (Day) (Year)

7 AGE 75 yrs. 6 mos. 13 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired Officer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto. Co.

10 NAME OF FATHER Joshua Mullineaux

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie Nickerson

13 BIRTHPLACE OF MOTHER (State or country) Balto Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Mullineaux  
(Address) Woodlawn Md

15 Filed 7/28 1930 mn. Bupper  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 23 1930 to July 27 1930, that I last saw him alive on July 27 1930, and that death occurred on the date stated above, at 8:40 A. M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Cerebral Hemorrhage  
Secondary

(Signed) Dr. J. Overholt M. D.  
7/27 1930 (Address) Woodlawn Md

\*State the Disease Causing Death, or, in death from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn July 29/30

20 UNDERTAKER ADDRESS

Dr. Marshall

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PULPERAL septicaemia," "PULPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent needless correspondence. The data is essential and should be obtained before the certificate is permanently filed.

RECEIVED  
JUL 16 1930  
U. S. DEPT. OF COM.  
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

07722

# STATE OF MARYLAND CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County Baltimore

Registration Dist. No. 52

Village or City Mount Wilson (No. Mt Wilson Branch)  
Maryland Tuberculosis Sanatorium  
2 FULL NAME Mrs Bessie Munk

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH June 7, 1904  
(Month) (Day) (Year)

7 AGE 26 yrs. 1 mos. 11 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Georgia

10 NAME OF FATHER Edward Bullock

11 BIRTHPLACE OF FATHER (State or country) Georgia

12 MAIDEN NAME OF MOTHER Onie Ramsey

13 BIRTHPLACE OF MOTHER (State or country) Georgia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Munk  
(Address) 3730 Mt. Pleasant ave

15 Filed July 19 1930 at Balt. Md  
D. E. Nichol Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 26, 1930, to July 18, 1930, that I last saw her alive on July 18, 1930.

and that death occurred on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary

(Signed) John A. Smith (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
July 18 1930 (Address) Mt. Wilson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 22 ds. In the 8 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? (?)

Former or usual residence 3730 Mt. Pleasant Ave, Balt. Md

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL July 22 1930

20 UNDERTAKER Lilly & Zeiler Inc. ADDRESS 403 S. Washington St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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AUG 2 1930

BUREAU

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## 1 PLACE OF DEATH

County

Baltimore

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 32

Village or City

Parkville(No. 31Linganore AVE

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs Ella C Munroe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

Nov. 141851

(Month)

(Day)

(Year)

7 AGE

79 yrs.14 mos.14 ds.

If LESS than

1 day \_\_\_\_ hrs.

or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed or (employer)

for Brother9 BIRTHPLACE  
(State or country)Baltimore Co10 NAME OF  
FATHERBenjamin Hoard11 BIRTHPLACE  
OF FATHER  
(State or country)Baltimore Co12 MAIDEN NAME  
OF MOTHERElizabeth Hoard13 BIRTHPLACE  
OF MOTHER  
(State or Country)Baltimore Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Howard Munroe

(Address)

Parkville

15

Filed

12/141930A. M. Bacon

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 21930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
October 24 1930 to December 2 1930that I last saw her alive on December 2 1930and that death occurred on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH \* was as follows:

Chronic Myocarditisa number of years

(Duration) yrs. mos. ds.

Contributory  
SecondaryArteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Morris B. Green M. D.See 4 1930 (Address) Hamilton Baltimore Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wanagh ChapelDec 5 1930

20 UNDERTAKER

ADDRESS

John Burns Sons Towson Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 8 1931

BUREAU

WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore Co

Village or City

Randrestown

No.

Campfield Rd.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registration Dist. No.

31

2 FULL NAME

Emilia M. Murgert

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Widow

6 DATE OF BIRTH

March 7

(Month)

(Day)

856

(Year)

7 AGE

74 3 9

If LESS than  
1 day.... hrs.  
..... yrs. .... mos. .... ds. or .... min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore Md.

10 NAME OF FATHER

Fred. Schlemmer

11 BIRTHPLACE OF FATHER

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Herrin's Klump

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Homer Reed.

(Address)

15

Filed

6/16/1920

M. H. Bueffer

Registrar

07154

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 2. 16

(Month)

(Day)

30, 1920 (Year)

17

I HEREBY CERTIFY That I attended the deceased from

June 1, 1920

to June 16, 1920

that I last saw her alive on

June 14, 1920

and that death occurred on the date stated above, at 4 P.M.

THE CAUSE OF DEATH was as follows:

Chronic interstitial nephritis

Contributory  
Secondary

(Duration)

5 yrs.

mos.

da.

Cardiac aschemia

(Duration)

8 yrs.

mos.

da.

(Signed)

Geo. W. H. M. D.

June 1, 1920

(Address)

3002 Garrison Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

..... yrs.

..... mos.

..... da.

In the State

..... yrs.

..... mos.

..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

18 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cem.

6-18-20

20 UNDERTAKER

ADDRESS

Mrs Chas A G Rohde 2327

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

BaltimoreSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 43Village or City Owerlea (No. 6 W. Owerlea Ave. St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Catherine C. Minkler

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

Nov. 5, 1889  
(Month) (Day) (Year)

7 AGE

41 yrs. 1 mos. 21 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Harry W. Gail

11 BIRTHPLACE OF FATHER

Maryland

12 MAIDEN NAME OF MOTHER

Emma S. Aulbach

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward C. Minkler

(Address)

6 W. Owerlea Ave.

15 Filed

12/29 1930 G. A. Fenty M.D.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 26, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 9, 1930 to Dec 26, 1930, that I last saw her alive on Dec 26, 1930and that death occurred on the date stated above, at 8 P. m.  
The CAUSE OF DEATH \* was as follows:Carcinoma (Pancreas)Contributory  
Secondary(Duration) 8 yrs. 0 mos. 0 ds.(Signed) Walter W. White M.D.  
Dec 27, 1930 (Address) 1800 St Paul

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Immanuel Cemetery Dec 29, 1930

20 UNDERTAKER

ADDRESS

Frederick Lassabron 7401 Belair Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU OF  
JAN 3 1931



WRITE IN INK ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

Village or City Catonsville (No. \_\_\_\_\_)

16 Wade Ave.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Anna M. Murphy

12865 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, Married  
WIDOWED, OR DIVORCED  
(Write the word)

6 DATE OF BIRTH March 5, 1888  
(Month) (Day) (Year)

7 AGE 42 yrs. 7 mos. 26 ds. or min.?  
If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas Roache

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Stafford

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles P. Murphy (husband)  
(Address) 16 Wade Ave., Catonsville

15 Filed 11/1 1923 W. H. Anderson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 31, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 26, 1923 to Oct 31, 1923

that I last saw her alive on Oct 31, 1923

and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH \* was as follows:

Broncho Pneumonia

(Duration) 6 yrs. 6 mos. 6 ds.

Contributory  
Secondary

(Duration) 6 yrs. 6 mos. 6 ds.

(Signed) Marshall B. West M. D.  
Nov 1, 1923 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral Cem. DATE OF BURIAL 11/3/30

20 UNDERTAKER W. H. Anderson ADDRESS 1101 Edmondson Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E.haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup>PLACE OF DEATH  
County Baltimore

04014 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 37

Village or City Lutherville (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup>FULL NAME William Henry Mayers Sr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Jan 13 1877  
(Month) (Day) (Year)

7 AGE 52 yrs. 2 mos. 19 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer.  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John T. Mayers

11 BIRTHPLACE OF FATHER (State or country) not known

12 MAIDEN NAME OF MOTHER Kate Robinson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) was Beatie Mayers  
(Address) Lutherville and R.F.D.

15 Filed April 5 1930 B. B. [Signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar. 1 1929 to Apr. 2 1930, that I last saw her alive on Mar. 30 1930,

and that death occurred on the date stated above, at 11 m. The CAUSE OF DEATH \* was as follows:

Carcinoma of Stomach  
(Duration) \_\_\_\_\_ yrs. 5 mos. \_\_\_\_\_ ds.

Contributory Secondary (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) B. B. [Signature] M. D.  
Apr 4 1930 (Address) Legas Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mayers Cemetery DATE OF BURIAL April 6, 1930

20 UNDERTAKER John Brown Sons ADDRESS Del. 7-30



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Tanner (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH

County

Baltimore

04015

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 43

Village or City

Rosedale (No. Seiling Ave, St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry John Myers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

April 22, 1930  
(Month) (Day) (Year)

7 AGE

yrs. 3 ds. OR LESS than 1 day, hrs. min. ?

OCCUPATION  
(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE  
(State or country)

Maryland

10 NAME OF FATHER

Henry John Myers

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ada Bartenfelter

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry John Myers

(Address)

Rosedale, Md.

15

Filed

4/26, 1930 G. A. Futz

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

April 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930 to April 25, 1930

that I last saw him alive on April 25, 1930 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH was as follows:

Spina Bifida Meningocele  
Hydrocephalus  
Rupture of Spleen  
(Duration) yrs. mos. ds.Contributory  
SecondaryMeningitis  
(Duration) yrs. mos. 2 ds.

(Signed)

B. M. C. M. D.  
191 (Address) 5631 Highland Rd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glen Lutheran Cemetery April 26, 1930

20 UNDERTAKER

ADDRESS

Frederick Esselman, 1015 Sullivan

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscle*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 2 1930  
BUREAU V. A.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			181 05301		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Balto</u>			Registration Dist. No. <u>44</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
Village or City <u>Essex</u> (No. <u>Essex Ave near Eastern</u> St. <u>Ward</u> )						
2 FULL NAME <u>Nelson H. Myers</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>May 26</u> , 192 <u>30</u>			
6 DATE OF BIRTH <u>Apr 14</u> , 192 <u>9</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>5/6/30</u> 192 <u>30</u> to <u>5/23</u> 192 <u>30</u>			
7 AGE <u>1</u> yrs. <u>1</u> mos. <u>12</u> ds. or min.?			that I last saw him alive on <u>5/23</u> , 192 <u>30</u>			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer)			and that death occurred on the date stated above, at <u>6:00</u> a.m. The CAUSE OF DEATH * was as follows: <u>Influenza</u>			
9 BIRTHPLACE (State or country) <u>Balto County</u>			Contributory <u>Bronchitis Pneumonia</u> Secondary <u>St. Vincent</u> (Duration) <u>15</u> ds. (Address) <u>633.5. Conkling</u>			
10 NAME OF FATHER <u>John H. Myers</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
11 BIRTHPLACE OF FATHER (State or country) <u>Balto</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>326/30</u> yrs. <u>10</u> mos. <u>10</u> ds. In the State <u>10</u> yrs. <u>10</u> mos. <u>10</u> ds.			
12 MAIDEN NAME OF MOTHER <u>Alberta Bartell</u>			Where was disease contracted, if not at place of death?			
13 BIRTHPLACE OF MOTHER (State or Country) <u>Balto</u>			Former or usual residence			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John H. Myers</u> (Address) <u>Essex Md</u>						
15 Filed <u>May 26</u> 192 <u>30</u> <u>John E. Connolly</u> Registrar						
19 PLACE OF BURIAL OR REMOVAL <u>Schwartz</u>			DATE OF BURIAL <u>May 28</u> , 19 <u>30</u>			
20 UNDERTAKER <u>Phil Herring</u>			ADDRESS <u>2016 Orleans St.</u>			

6338.  
Conklin  
St. McDaniel

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Campmaster, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Seaman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Branchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a] questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Baltimore*

08990

(91-2)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *30*

Village or City

*Catonsville Md. Spring Grove Hosp.*

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Roger J. Myers*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*white*5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*July 10 1851*  
(Month) (Day) (Year)

7 AGE

*79 yrs. 1 mos. - ds. or min.?*  
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Farmer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)*Maryland*

10 NAME OF FATHER

*John Myers*11 BIRTHPLACE OF FATHER  
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Johnson*13 BIRTHPLACE OF MOTHER  
(State or Country)*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Hospital record.*

(Address)

15 Filed

*7/11 1923*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*August 10 1923*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Sept 1 1921 to Aug 10 1923*that I last saw him alive on *Aug 9 1923*and that death occurred on the date stated above, at *3:15 a.m.*

The CAUSE OF DEATH \* was as follows:

*arterio sclerosis*(Duration) *15 yrs. mos. ds.*Contributory  
Secondary*Coronary & Right arm & upper*(Duration) *10 yrs. mos. ds.*

(Signed)

*John G. Runkel M. D.*  
*Aug 11 1923 (Address) Catonsville*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *4 1/2 yrs. 11 mos. 3 ds.*In the State *10 yrs. mos. ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

*Silver Run Md.*

19 PLACE OF BURIAL OR REMOVAL

*Silver Run Cemetery Md.*

DATE OF BURIAL

*Aug. 14 1923*

20 UNDERTAKER

*St. A. Sharrer Son*

ADDRESS

*Westminster Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmorrhage," "Hæmaturia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 10 1930  
BURMA

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore Co

Village or City Stinson Run

2 FULL NAME Baty Ingers

2078991 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug 4 Aug 4 (Month) Aug (Day) 1 (Year)

7 AGE Born dead yrs. — mos. — ds. or min.? If LESS than 1 day hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work — (b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Stinson Run

10 NAME OF FATHER John Meyer

11 BIRTHPLACE OF FATHER (State or country) Back River

12 MAIDEN NAME OF MOTHER Matie Meyer

13 BIRTHPLACE OF MOTHER (State or Country) Back River

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) St Stephens Cen

(Address) By mother Matie Meyer

15 Filed Aug 5 1930 John G. Comstock Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 4, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 4 1930 to Aug 4 1930

that I last saw her alive on Aug 4 1930

and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH \* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) James F. White M. D.

8/5 1930 (Address) Easton, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Stephen Cen Aug 5, 1930

20 UNDERTAKER ADDRESS

Mrs R A Elliott 1725 Rogers

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.); "Dropsy," "Echausion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 8 1930  
BUREAU



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
1926

RECEIVED  
MAR 26 1926  
BUREAU V. A.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			04016		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			(129)		Registration Dist. No. <u>41</u>	
Village or City <u>New Pittsburg</u> (No. <u>6739</u> )			<u>Trappe road</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>William Lee Nealis</u>						
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		16 DATE OF DEATH <u>April 5, 1938</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Sept 17, 1863</u> (Month) (Day) (Year)				17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 5<sup>th</sup> 1930</u> to <u>April 5<sup>th</sup> 1930</u> that I last saw him alive on <u>April 3<sup>rd</sup> 1930</u> and that death occurred on the date stated above, at <u>10-2 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Nephritis, chronic, acute</u>		
7 AGE <u>67</u> yrs. <u>6</u> mos. <u>18</u> ds. or min.?				If LESS than 1 day, hrs. or min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Carpenter &amp; Builder</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>self.</u>				Contributory Secondary <u>Senility</u> (Duration) yrs. <u>4</u> mos. ds.		
9 BIRTHPLACE (State or country) <u>W. Va</u>				(Signed) <u>Adams Tod</u> M. D. <u>4/6/38</u> 192 (Address) <u>4700 Eastern Ave</u>		
10 NAME OF FATHER <u>Don't Know</u>				*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
11 BIRTHPLACE OF FATHER <u>W. Va</u>				18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.		
12 MAIDEN NAME OF MOTHER <u>Don't Know</u>				Where was disease contracted, if not at place of death?		
13 BIRTHPLACE OF MOTHER <u>W. Va</u>				Former or usual residence		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Amabelle Nealis</u> (Address) <u>6739 Trappe road</u>				19 PLACE OF BURIAL OR REMOVAL <u>Cumberland Md</u>		
15 Filed <u>4/6/38</u> 192 <u>W. L. Nealis</u> Registrar				20 UNDERTAKER <u>John White</u>		
				DATE OF BURIAL <u>April 7, 1938</u>		
				ADDRESS <u>208 Orleans</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY taken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 5 1900  
BUREAU



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1 PLACE OF DEATH County <u>Maryland</u>		06498 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Arbutus</u> (No. <u>129</u> )		Registration Dist. No. <u>42</u>	
2 FULL NAME <u>Chas. S. Neighoff, Sr.</u>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>June 28, 1930</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>Sec 4 1854</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>June 19, 1930</u> to <u>June 28, 1930</u> that I last saw him alive on <u>June 29, 1930</u> and that death occurred on the date stated above, at <u>2:00 p.m.</u>
7 AGE <u>75</u> yrs. <u>6</u> mos. <u>24</u> ds. or min. ? If LESS than 1 day....hrs.			The CAUSE OF DEATH was as follows: <u>chronic nephritis</u>
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Carpenter</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>self.</u>			Contributory Secondary <u>urine</u> <u>bone</u> (Duration) .... yrs. .... mos. .... da.
9 BIRTHPLACE (State or country) <u>Maryland</u>			(Signed) <u>Russell</u> M. D. <u>June 29, 1930</u> (Address) <u>2708 Hallway St. S.E.</u>
PARENTS	10 NAME OF FATHER <u>Jacob F. Neighoff</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death .... yrs. .... mos. .... da. In the State, .... yrs. .... mos. .... da.
	12 MAIDEN NAME OF MOTHER <u>Mary Brodwin</u>		Where was disease contracted, if not at place of death? Former or usual residence.....
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		19 PLACE OF BURIAL OR REMOVAL <u>2nd Wood Cemetery</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Isabella Dipp</u> (Address) <u>Old Washington Rd.</u>			DATE OF BURIAL <u>July 1, 1930</u>
Filed <u>June 30, 1930</u> <u>Geo. M. Kieffer</u> Registrar			20 UNDERTAKER <u>Bernard A. Link 784 Washington Blvd.</u>

# REVISED UNITED STATES' STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningitis* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 40 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state **MEANS** or **INJURY** and qualify as **ACCIDENTAL**, **STUCIDAL**, or **HOMICIDAL**, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retroler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 3 1930

BUREAU



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

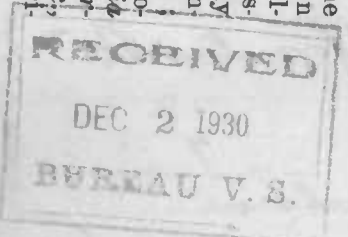
[Approved by U. S. Census and American Public Health Asso.]

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day Laborer*, *Farm Laborer*, *Laborer—Coal Mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name or-

gin "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Broncho-pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore Co

07723

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Burton (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elizabeth Harrison Neilson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED

6 DATE OF BIRTH May 7 1884  
(Month) (Day) (Year)

7 AGE 76 yrs. 2 mos. 15 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Philadelphia Penn.

10 NAME OF FATHER Thomas Harrison

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Sarah C Richard

13 BIRTHPLACE OF MOTHER (State or Country) Chesler Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Neilson(Address) 526 West 113 St.

15 Filed July 23 1936 Wm C. G. O'Neil Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 22 1936  
(Month) 22 (Day) 1936 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 29 1936 to July 22 1936, that I last saw him alive on July 22 1936

and that death occurred on the date stated above at 574 P.m.

The CAUSE OF DEATH \* was as follows:

Acute cholecystitis(Duration) - yrs. 2 mos. 24 ds.Contributory Secondary Senile cardiac-morbus4 renal failure (Duration) - yrs. 1 mos. 22 ds.(Signed) E. H. E. Van Ness M. D.7.23 1936 (Address) 1575 Park Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. - ds. In the State - yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Towresdale Penn

DATE OF BURIAL

July 24 1936

20 UNDERTAKER

Henry H. Buckner

ADDRESS

McClure



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 7 1900  
BUREAU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Overlea (No. 20)

Willow Avenue

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME FRANCES NELSON

Registration Dist. No. 43

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH February 16th 1852  
(Month) (Day) (Year)

7 AGE 78 yrs. 10 mos. 7 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER George Jackson

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George F. Nelson

(Address) 20 Willow Ave., Overlea

15 Filed 12/26 1930 G. A. Fitch Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23rd 1930

(Month) Dec (Day) 20 (Year) 30

17 I HEREBY CERTIFY, That I attended the deceased from Dec 23 19230 to Dec 23 19230

that I last saw him alive on Dec 23 19230

and that death occurred on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH \* was as follows:

Phthisis (Consumption)

(Duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Smoking

(Signed) W. L. Cherry M. D.

12/26 1930 (Address) Green Hill

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Carmel Cemetery DATE OF BURIAL Dec. 26, 1930

20 UNDERTAKER Frederick Lassahn ADDRESS 7401 Belair Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 3 1911  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Batonsville (No. 148) Spring Grove Hospital

2 FULL NAME John Nelson

10167 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH March 20, 1868  
(Month) (Day) (Year)

7 AGE 62 yrs. 6 mos. 19 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Jas. Nelson

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Spring Grove Hospital  
(Address) Reverend

15 Filed 9/30 1930 Ph. Andrew Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 29, 1915 to Sept 30, 1930  
that I last saw him alive on Sept 29, 1930

and that death occurred on the date stated above, at \_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Cerebral Embolism  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 10 ds.  
Contributory Concussions  
Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 3 ds.

(Signed) Dr. E. C. Garrett M. D.  
Sept 30, 1930 (Address) Batonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 14 yrs. 9 mos. 0 ds. In the 40 State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? at place of death  
Former or usual residence Cambridge Md

19 PLACE OF BURIAL OR REMOVAL Spring Grove Cemetery DATE OF BURIAL 9/30 1930

20 UNDERTAKER Spring Grove Hospital ADDRESS \_\_\_\_\_

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Heart failure," "Old Age," "Shock," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 4 1933

BUREAU



06034

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 31

1 PLACE OF DEATH

County Baltimore

(123)

Village or City Randalltown (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah Catherine Nelson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)6 DATE OF BIRTH Sept. 17 1855  
(Month) (Day) (Year)7 AGE 72 yrs. 7 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER William Wagner11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Lucie Powell13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. Nelson(Address) Randalltown15 Filed May 15 1930 M. S. Suffer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 15 1930  
(Month) (Day) (Year)I HEREBY CERTIFY that I attended the deceased from May 7 1930 to May 15 1930 that I last saw her alive on May 15 1930 and that death occurred on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH \* was as follows:

Cholecystitis + lithiasis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory  
Secondary(Signed) Wm. E. Martin M. D.  
May 15 1930 (Address) Randalltown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Methodist Church Cem DATE OF BURIAL May 17 193020 UNDERTAKER Meer & Son ADDRESS Sykesville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

-7, S. No. 1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 2 1930

BUREAU V.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

Dundalk

6758 Woodley

Village or City \_\_\_\_\_ (No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Paul Nemzek

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

## 6 DATE OF BIRTH

Dec 25 1928

(Month) (Day) (Year)

## 7 AGE

9 yrs. 4 mos. 4 ds. or min.?If LESS than  
1 day hrs.  
or min.?

## 8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

## 9 BIRTHPLACE

(State or country)

Dundlak Md

## 10 NAME OF

FATHER

Albert A Nemzek

## 11 BIRTHPLACE

OF FATHER

Minn

## 12 MAIDEN NAME

OF MOTHER

Esther Lugar

## 13 BIRTHPLACE

OF MOTHER

Pa

(State or Country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert A Numzek6758 Woodley Rd

(Address)

## 15

Filed

9/29/30

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 29, 1930  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

Sept 27, 1930 to Sept 29, 1930,that I last saw him alive on Sept 29, 1930,and that death occurred on the date stated above, at 5:30 A. M.The CAUSE OF DEATH \* was as follows: Scalded by hot water in  
the bath tub, & accidentally turning on the spigot & using  
Second Degree Burns  
(accidental)(Duration) yrs. mos. 2 ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Sept. 29, 1930 (Address) Dundalk, Md.\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Phila Pa Oct 1, 1930

## 20 UNDERTAKER

## ADDRESS

John Ullrich 2008 Orleans

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL, peritonitis," etc. State cause for which surgical treatment was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 4 1930

BUREAU

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Balto.

Village or City Middlebrough (No. 142)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 44

2 FULL NAME Harren Ernest Riblett (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov. 20, 1928  
(Month) (Day) (Year)

7 AGE 2 yrs. — mos. 1 ds. or — min. If LESS than 1 day — hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Balto. Co.

10 NAME OF FATHER Ernest C. Riblett

11 BIRTHPLACE OF FATHER (State or country) Salisbury Md.

12 MAIDEN NAME OF MOTHER Rochester C. Repp.

13 BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest C. Riblett  
(Address) Middlebrough Md.

15 Filed Nov. 22 1930 John G. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 16 1930 to Nov 21, 1930.

that I last saw him alive on Nov 21, 1930.

and that death occurred on the date stated above, at 2:40 PM.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia  
(Duration) 5 yrs. — mos. — ds.

Contributory Secondary

(Signed) J. J. White M. D.  
Nov. 22 1930 (Address) Essex Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL Nov. 22, 1930

20 UNDERTAKER John G. Connolly ADDRESS Essex

*For authentication to add seal and date on back certificate Nov. 20, 1930.*  
85. 12. 1. 20.

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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DEC 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

10171

(74-2)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 837Village or City Sparks (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Amie Bartholdt Nicoll

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH April 17, 1850  
(Month) (Day) (Year)

7 AGE 80 yrs. 5 mos. 9 ds. If LESS than 1 day .... hrs. or .... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Blind, Pa.

10 NAME OF FATHER Christian Bartholdt

11 BIRTHPLACE OF FATHER (State or country) Alsace, Lorraine

12 MAIDEN NAME OF MOTHER Margaret Muller

13 BIRTHPLACE OF MOTHER (State or country) Wittenburg, Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benj. B. Nicoll  
(Address) Louisa, Md.

15 Filed Sept 27 1930 B. J. Bannaford  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 26, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1920 to Sept. 26, 1930, that I last saw him alive on Sept. 25, 1930.

and that death occurred on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

Contributory (Duration) yrs. mos. ds.  
Secondary Arterio Sclerosis  
over 10 yrs.

(Signed) H. C. Kress M. D.  
Sept. 27 1930 (Address) 5600 York Rd. Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hereford, Maryland DATE OF BURIAL Sept. 29, 1930

20 UNDERTAKER Wm C Brooks & Son ADDRESS Sparks, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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OCT 6 1930  
BUREAU V. S.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Rosedale (No. Philadelphia Rd St.  Ward )

2 FULL NAME Eva Elizabeth Nickel

02660 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 3, 1869  
(Month) (Day) (Year)

7 AGE 60 yrs. 9 mos. 4 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Bernard Storck

11 BIRTHPLACE OF FATHER (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Ger.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Ulrich W. Nickel

(Address) Phila Rd. Rosedale

15 Filed Mar. 10 1930 John G. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 1927 to March 7, 19230  
that I last saw or alive on March 7, 19230

and that death occurred on the date stated above, at 12550 M.  
The CAUSE OF DEATH \* was as follows:

Sarcoma of the Lung

(Duration) yrs. mos. ds.

Contributor  
Secondary Metastases of brain  
(Duration) yrs. mos. ds.

(Signed) Lucas Krause M. D.  
Mar 9 1930 Address 12550 Phila Rd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Roxton Park Cem. DATE OF BURIAL Mar 10, 1930

20 UNDERTAKER Wm. H. Kuer ADDRESS North Pa

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state CAUSE OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound by rapid-firing*; *Struck by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Dr. Louis Brand  
Med. Arts Bldg.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07724

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 42

Village or City Lacrosse (No. Elizabeth ave St.: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Albert Nicholas (Nicholas)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Oct 28 1880  
(Month) (Day) (Year)

7 AGE 59 yrs. 7 mos. 21 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Special officer  
(b) General nature of industry, business, or establishment in which employed or (employer) Rare Truck.

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF FATHER George Nicholas

11 BIRTHPLACE OF FATHER  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Zell

13 BIRTHPLACE OF MOTHER  
(State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Estella Nicholas

(Address) Lacrosse

15 Filed July 19 1930 Richard Kieffer Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 18 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 14 1930 to July 18 1930, that I last saw him alive on July 18 1930

and that death occurred on the date stated above, at 3 p. m.

The CAUSE OF DEATH \* was as follows:

Carcinoma of  
throat

(Duration) 1 yrs. 6 mos. \_\_\_\_ ds.

Contributory  
Secondary Carcinomatosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 10 ds.

(Signed) Raymond Glance M. D.

July 18 1930 (Address) 8308 Hollins Ave Rd

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Landon Park Cemetery 7/21 1930

20 UNDERTAKER ADDRESS

Kentucky W. Mears & Son 805 W. Calvert St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary steam, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Lumber—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the **DEATH CAUSING DISEASE**, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asbemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL puerperitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is taken or thoroughly and all questions answered in detail, it will preserve the other correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Randallstown (No. ....)

2 FULL NAME Bessie Nickoles

12866

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 31

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 13 1930  
(Month) (Day) (Year)

7 AGE ..... If LESS than 1 day ..... hrs. ..... yrs. ..... mos. ..... ds. or ..... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jos Nickoles

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie M. Shufley

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bessie M. Shufley

(Address) Randallstown

15 Filed 9/14 1930 Mrs. B. B. B. B. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 13 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 13 1930 to Oct 13 1930  
that I last saw him alive on ..... 19.....

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Stellthorn  
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory  
Secondary

(Signed) Wm. E. Martin M.D.  
Oct 4 1930 (Address) Randallstown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

In Keeney (Father) Oct 15 1930

20 UNDERTAKER Joseph Nickoles ADDRESS Randallstown



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

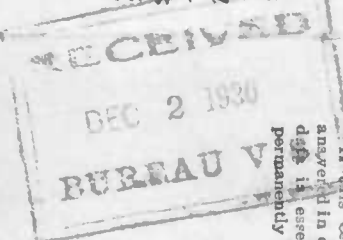
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up, on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A check in the left margin is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

13579

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Dundalk (No. 1931 New Pittsburgh Ave Ward) (If death occurred in a hospital or Institution, give its NAME instead of street and number.)2 FULL NAME Johanna Mathilda Nilsson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow6 DATE OF BIRTH Dec 31, 1888 (Month) (Day) (Year)7 AGE 74 yrs. 0 mos. 8 ds. or LESS than 1 day hrs. min.?8 OCCUPATION (a) Trade, profession or particular kind of work at home (b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Sweden10 NAME OF FATHER Bergelson11 BIRTHPLACE OF FATHER (State or country) Sweden12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Evelyn Booley(Address) 1931 New Pittsburgh Ave15 Filed 10/07/30 J. McLaughlin Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 9, 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 1, 1925, to Nov 9, 1930, that I last saw her alive on Nov 1, 1930,and that death occurred on the date stated above, at m. The CAUSE OF DEATH \* was as follows:Chronic MyocarditisContributory (Duration) 5 yrs. — mos. — ds. Arteriosclerosis(Signed) Dr. R. P. Rier M. D. Nov 9, 1930 (Address) Dundalk, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oaklawn Cemetery DATE OF BURIAL Nov 11, 193020 UNDERTAKER Chas. S. Black 7420 North Ave ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Dr Rier Cor Kinship Rd + Home Centre

852 Committee  
Ralph Dean

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bro. chloepneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (trivially symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data ~~should be~~ <sup>may be</sup> entered before the certificate is ~~permanently filed.~~

NOV 18 1908

CITY AND COUNTY

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Owings Mills (No. \_\_\_\_\_)

2 FULL NAME Mary Polna Dine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 6, 1903  
(Month) (Day) (Year)

7 AGE 26 yrs. 3 mos. 26 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Inmate  
(b) General nature of industry Rosewood State Training School  
business, or establishment in which employed or (employer) Owings Mills, Md.

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER William H. Dine

11 BIRTHPLACE OF FATHER (State or country) Texas

12 MAIDEN NAME OF MOTHER Hanna Sloan

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Institutional Records  
(Address) Rosewood State Training School, Owings Mills, Md.

15 Filed Feb 4, 1930 Owings Mills  
Registrar

01409

(31)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 17, 1924 to Feb 1, 1930, that I last saw her alive on Feb 1, 1930,

and that death occurred on the date stated above, at 10:45 P. m.  
The CAUSE OF DEATH \* was as follows:

Pulmonary tuberculosis

(Duration) Unknown ds.  
Contributory Tuberculous Enteritis  
Secondary (terminal)  
(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) George C. Medaury M. D.  
Feb 1, 1930 (Address) Owings Mills

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 17 yrs. 7 mos. 10 ds. In the State Unknown yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Baltimore Co., Ind.

19 PLACE OF BURIAL OR REMOVAL Rosewood Cemetery DATE OF BURIAL Feb 3, 1930  
20 UNDERTAKER J. F. Coline Reardon ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

*Transcribed Feb 1-1933*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1933  
BUREAU OF



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07725

(31)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 22

Village or City Mount Wilson (No. Mount Wilson Branch St. Maryland Tuberculosis Sanatorium Ward     ) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2 FULL NAME Mrs. Mildred F. Nokes

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH January 2<sup>nd</sup>, 1908  
(Month) (Day) (Year)

7 AGE 22 yrs. 6 mos. 23 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Massachusetts

10 NAME OF FATHER Elmer W. Leonard

11 BIRTHPLACE OF FATHER (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Maudie Cahoon

13 BIRTHPLACE OF MOTHER (State or country) Massachusetts

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Nokes

(Address) 741 Pen Lucy Ave. Balt. Md.

15 Filed July 25 1930 E. E. Nichol  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 22, 1930 to July 25, 1930  
that I last saw her alive on July 25, 1930

and that death occurred on the date stated above, at 3:15 P. m.  
The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) 0 yrs. 7 mos. (2) ds.  
Contributory None  
Secondary

(Signed) John A. Smith M. D.  
July 25 1930 (Address) Mount Wilson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 1 mos. 3 ds. In the State 1 yrs. 10 mos. (2) ds.

Where was disease contracted, if not at place of death Unknown

Former or usual residence 741 Pen Lucy Ave. Baltimore

19 PLACE OF BURIAL OR REMOVAL Protest Hill Cemetery DATE OF BURIAL July 28, 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 M

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tumia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-pneumonia* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Dysphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 7 1930  
BUREAU V. E.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City St. Helena (No. \_\_\_\_\_)

2 FULL NAME still born infant Morris

07726

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. HH

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX undetermined COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH July 5<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Frank Morris

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Matilda R. Fleetwood

13 BIRTHPLACE OF MOTHER (State or Country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Matilda R. Morris

(Address) St. Helena

15 Filed July 6, 1930 G. H. McCormick  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 5<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192 to \_\_\_\_\_ 192,

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 192,

and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH \* was as follows:

still born (2 mo)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) G. H. McCormick M. D.  
July 6, 1930 (Address) Openhurst

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

sent to Johns Hopkins, 1930

20 UNDERTAKER ADDRESS

Anatomical Laboratory



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

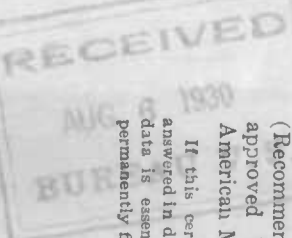
(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Grip"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*Baltimore*

10170

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *30*

Village or City

*Franklin*

(No. ....)

*Ingleside Ave*

St. ....

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*George Nuetzel*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Married*

6 DATE OF BIRTH

*June 3, 1880*  
(Month) (Day) (Year)

7 AGE

*72 yrs. 3 mos. 10 ds.*  
If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Merchant*

(b) General nature of industry business, or establishment in which employed or (employer)

*Retired 9 years*

9 BIRTHPLACE

(State or country)

*Germany*

10 NAME OF FATHER

*Conrad Nuetzel*

11 BIRTHPLACE OF FATHER

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Sartorius*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Dorothea Nuetzel*

(Address)

*Ingleside Ave*

15

Filed

*9/17/30*

1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Sept 16, 1930*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That, attended the deceased from

*Sept 14, 1930 to Sept 16, 1930*that I last saw him alive on *Sept 16, 1930*and that death occurred on the date stated above, at *10:32 a.m.*

The CAUSE OF DEATH \* was as follows:

*Cerebral Haemorrhage*

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributor

Secondary

*Arteriosclerosis**Sept 16, 1930* (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

*Augustine P. Vondra, M.D.**Sept 16, 1930* (Address) *4818 Edmondson Ave*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the

State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Boravia Ave**Sept 19, 1930*

20 UNDERTAKER

ADDRESS

*John Lelior**2008 Orleans*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

OCT 4 1930

BUREAU OF

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping-cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by antipathic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *Edema*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

Dr Van der Schuer  
Edmondson  
Cooke Lane

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1 PLACE OF DEATH  
County Baltimore

07155 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City Lanston (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Katharine Lee Moyné Fisher Ober

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH March 21, 1900  
(Month) (Day) (Year)

7 AGE 30 yrs. 2 mos. 20 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Buxton, Maryland

10 NAME OF FATHER Janon Fisher

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 M maiden NAME OF MOTHER Katharine Lee Moyné

13 BIRTHPLACE OF MOTHER (State or Country) Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben A. Fisher  
(Address) 715 Park Ave

15 Filed June 11, 1930 Wm P. Sutter  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1925 to June 11, 1930

that I last saw him alive on June 9, 1930

and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis

(Duration) 5 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Ben A. Fisher M. D.  
June 11, 1930 (Address) 715 Park Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St Thomas German Tent DATE OF BURIAL June 12, 1930

20 UNDERTAKER Wm P. Sutter ADDRESS 611 E. Calver St. Calver

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word, or term on the first line will be sufficient, e. g., *Farmer* or *Teamster*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *letanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

715 Park Ave  
New York



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

1920

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Pneumonia Subcutaneous  
Subcutaneous PeritonitisContributory  
Secondary

(Signed)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the State

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Balto.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Balto.

Village or City

Catonsville

(No.)

Rolling Rd.

Registration Dist. No.

30

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edward O. Connor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, Single

WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

November 3rd, 1911

(Month)

(Day)

(Year)

7 AGE

18 yrs. 10 mos. 25 ds.If LESS than  
1 day.....hrs.  
or.....min.?

8 OCCUPATION

(a) Trade, profession or  
particular kind of workPaper Hanger(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore, Md.

10 NAME OF

FATHER

Martin O. Connor

11 BIRTHPLACE

OF FATHER

(State or country)

Balto, Md.

12 MAIDEN NAME

OF MOTHER

Carrie Walden

13 BIRTHPLACE

OF MOTHER

(State or Country)

Balto, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie O. Connor Mother(Address) 1015 S. Highland Ave

15

Filed

9/30 1930

Registrar

10172

(188-d)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 28th, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192.....to.....192.....

that I last saw h.....alive on.....192.....

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH \* was as follows:

Accidental Death:  
Both men were in an airplane (Edward O'Connor's)  
Robert Lyman), operated by Lyman. Tried to make a nose  
diver; misjudged distance, causing death of both men.  
Contributory  
Secondary  
1301 S. Highland Ave  
Connor  
192.....(Address).....  
192.....(Duration).....yrs.....mos.....ds.  
(Signed).....M. D.

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death.....yrs.....mos.....ds.In the  
State.....yrs.....mos.....ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Carmel Cem., Balto., 1st, 1930.

20 UNDERTAKER

ADDRESS

George A. Weber, 705 S. Ann St.,

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 4 1900  
BUREAU V. B.

MARGIN RESERVED FOR BINDING  
FAMILY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

13550

(109.2)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

3-3

Village or City

Near Rickettsburg 2nd

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John Charles C. Connor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Jan 13th 1854

7 AGE

76 yrs. 10 mos. 22 ds. or less than 1 day hrs. min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Carpenter

9 BIRTHPLACE

(State or country)

Washington D. C.

10 NAME OF FATHER

Peter Patrick C. Connor

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Jennie Paul

13 BIRTHPLACE OF MOTHER

(State or Country)

Washington D. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. R. C. Connor

(Address)

3010 Gaymans Falls Parkway, Landon Park Country

15 Filed

Nov. 22 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 22nd 1930

I HEREBY CERTIFY, That I attended the deceased from Nov 22nd 1930 to Nov 22nd 1930, that I last saw him alive on Nov 21st 1930,

and that death occurred on the date stated above, at 3 P. M. The CAUSE OF DEATH \* was as follows:

Paralysis of Heart

Contributory Secondary

(Signed)

J. F. MacBride, M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs. mos. ds.

In the State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Landon Park Cemetery

Nov. 25 1930

20 UNDERTAKER

Wm Cox

ADDRESS

St Paul &amp; York



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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U. S. G. 1930 1930 1930

V. g. No. 1

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 3 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Esles (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William J. Deligrath

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married6 DATE OF BIRTH January 3<sup>rd</sup> 1844  
(Month) (Day) (Year)7 AGE 85 yrs. 6 mos. 15 ds. or LESS than 1 day hrs. min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired Blacksmith  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Md. Balto Co10 NAME OF FATHER Abraham Deligrath11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Amelia Marcell13 BIRTHPLACE OF MOTHER Bayeux, France

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard R. Hunt(Address) Washington DC15 Filed Mar 3 1930 Samuel S. Miller Registrar

02108

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 28, 1930.  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 1 1929 to Feb. 28, 1930.that I last saw him alive on Feb. 28, 1930.and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage.(Duration) 3 yrs. 3 mos. 3 ds.Contributory Secondary Arterio Sclerosis(Duration) 3 yrs. 3 mos. 3 ds.(Signed) J. L. Yagle M. D.Mar 1 1930, (Address) New Freedom Pa

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 3 mos. 3 ds. In the State 3 yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Middletown Md DATE OF BURIAL March 3, 193020 UNDERTAKER P. N. Trabant ADDRESS Freeland Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scront, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
APR 7 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

01411

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Towson (No. 21 Pennsylvania Ave., St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME James P. Offutt

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)
----------------------	---------------------------------	---

## 6 DATE OF BIRTH

February 12, 1876  
 (Month) (Day) (Year)

## 7 AGE

53 yrs. 11 mos. 29 ds. or LESS than 1 day hrs. or min.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed or (employer)

## 9 BIRTHPLACE

(State or country)

Granite, Md.

## 10 NAME OF FATHER

Dr. Thomas Z. Offutt

## 11 BIRTHPLACE OF FATHER

(State or country)

Montgomery Co., Md.

## 12 MAIDEN NAME OF MOTHER

Maria E. A. Offutt

## 13 BIRTHPLACE OF MOTHER

(State or country)

Granite, Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Noah E. Offutt(Address) Cockeysville, Md.

## 15

Filed Feb 12 1930 J. P. Ryte  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb. 11, 1930  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from Jan. 14 1930 to Feb. 11 1930, that I last saw him alive on Feb. 1 1930.
and that death occurred on the date stated above, at 4 m.

The CAUSE OF DEATH was as follows:

Angina Pectoris
 (Duration) 30 ds.  
 Contributory Artery Sclerosis  
 Secondary Personal Knowledge 30 days  
 (Duration) 30 ds.

 (Signed) B. H. Ramsey M. D.  
Feb. 11 1930 (Address) Deep 5, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Druid Ridge Cemetery 2/13, 1930

## 20 UNDERTAKER

## ADDRESS

Henry W. Myers & Son 805 N. Calvert

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Formerly retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, using always the same acceptation for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Ferry"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, its fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 7 1910  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

08992 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Essex (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Bernard P. Ogle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 13, 1902  
(Month) (Day) (Year)

7 AGE 28 yrs. 3 mos. 27 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

## OCCUPATION

(a) Trade, profession or particular kind of work Presser  
(b) General nature of industry, business, or establishment in which employed or (employer) Central Overalls Comp.

9 BIRTHPLACE (State or country) Baltimore Md

10 NAME OF FATHER John Ogle

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Schroeder

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Ogle  
(Address) 609 N. East St.

15 Filed Aug 13 1930 John G. Connelley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 10th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Accidental drowning

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Jacob Hallman Croner M. D.  
192 (Address) Stemmers Run

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Paul's Catholic Church  
Essex

Aug 14 1930

20 UNDERTAKER

Wm Cook

ADDRESS 1217 Sauls St  
Baltimore  
city

If more blanks are needed, address State Registrar, 16 W. Seneca St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Terionaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emphysema," "Heart failure," "Haemorrhage," "Hæmaturia," "Hæmaturia," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

U. S. BUREAU OF  
CENSUS  
DEATHS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Baltimore

Relay Sanatorium

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

42

Village or City

Relay

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME in-lead of street and number.)

2 FULL NAME

Richard Lee O'Neal

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

October 24<sup>th</sup>, 1869

7 AGE

60 yrs. 11 mos. 6 ds. or min. ?

If LESS than

1 day....hrs.

OCCUPATION

(a) Trade, profession or particular kind of work

Hotel Owner

(b) General nature of industry business, or establishment in which employed or (employer)

Hotel Business

9 BIRTHPLACE

(State or country)

Indiana

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER ?

(State or country)

12 MAIDEN NAME OF MOTHER

Betty Cox

13 BIRTHPLACE OF MOTHER ?

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Marie O'Neal

(Address)

Fairmount W Va

15

File

Oct 31 1930

John O'Neal

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 1<sup>st</sup>, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

September 21<sup>st</sup>, 1930, to October 1<sup>st</sup>, 1930.that I last saw him alive on October 1<sup>st</sup>, 1930.

and that death occurred on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH was as follows:

Chronic Alcoholism with acute gastritis

(Duration) yrs. 2 mos. da.

Contributory Secondary

Coughing Bronchopneumonia of entire left lung

(Duration) yrs. 1 da.

(Signed) Lewis P. Gendley M.D.

October 1<sup>st</sup>, 1930 (Address) 305 31<sup>st</sup> St. Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 2 da. In the State, yrs. 2 da.

Where was disease contracted, if not at place of death? Home (Primary cause)

Former or usual residence Fairmount West Virginia

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Huntington W Va Oct 1, 1930

20 UNDERTAKER

ADDRESS

John O'Neal + Son 1900 Eubank Place



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

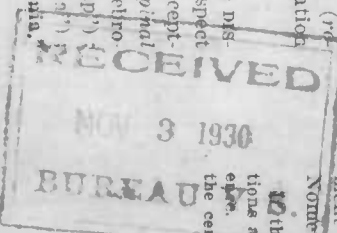
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Pinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. (Are should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Placement of Cause of Death.**—Name, first, the **LAST CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

"unqualified, is indefinite"); *Tuberculosis of lung*, *meninges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *days*; *Bronchopneumonia* (secondary), 10 *days*. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is permanently filed.



WRITING ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County

Baltimore

Village or City

Sunnybrook

No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

37

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Arthur Eugene Openshaw

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

October 22, 1904

(Month)

(Day)

(Year)

7 AGE

25 yrs. 11 mos. 10 ds. or min. ?

If LESS than  
1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Auto Mechanic

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore

PARENTS

10 NAME OF FATHER

Wesley Openshaw

11 BIRTHPLACE OF FATHER

(State or country)

England

12 MAIDEN NAME OF MOTHER

Josephine Palmer

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Josephine P. Openshaw

(Address)

White Hall Md.

15

Filed

Oct 3, 1930 B. B. Benson Md.

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 2, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

192... to

192...

that I last saw him alive on

192...

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Shot in left chest, entering heart - with shot gun Suicide

(Duration) yrs. mos. de.

Contributory  
Secondary

(Duration) yrs. mos. de.

(Signed) Emory W. Benson, P. Coroner

Oct. 2, 1930 (Address) Cockeysville Md.

\*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs. mos. da.

In the State... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former regular residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Liberty

Oct 5, 1930

20 UNDERTAKER

ADDRESS

P. Markham Son

White Hall Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

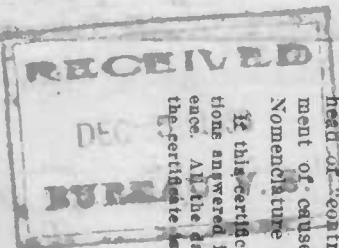
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not fully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto. Co.

Village or City Reisterstown <sup>md.</sup> (No. 31) Mt. Pleasant San. St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registration Dist. No. 33

2 FULL NAME Harry Oppel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec. 1, 1908  
(Month) (Day) (Year)

7 AGE 21 yrs. 6 mos. 18 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Packet Book maker  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER Joseph Oppel

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel Reiman

13 BIRTHPLACE OF MOTHER (State or Country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed June 18 1930 Small Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 3 1930 to June 18 1930

that I last saw him alive on June 18 1930

and that death occurred on the date stated above, at 6:30 P. m.  
The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. 30 mos. 30 ds.

Contributory  
Secondary

(Duration) 4 yrs. 30 mos. 30 ds.

(Signed) Albert F. Shier M. D.

June 18 1930 (Address) Reisterstown Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 15 mos. 15 ds. In the State 9 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence 137 N. Luzerne Ave.

19 PLACE OF BURIAL OR REMOVAL Chew Rossdale DATE OF BURIAL 6-19-1930

20 UNDERTAKER Jack Lewis, 1439 E. Balto. ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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## 1 PLACE OF DEATH

County BaltimoreVillage or City Sparrows Point. (No. 225)2 FULL NAME Nicholas OrdieSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Male</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Married</b> (Write the word)
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6 DATE OF BIRTH <b>October, 5th</b> (Month) (Day) (Year)	<b>1895</b>
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7 AGE <b>35</b> yrs. <u>1</u> mos. <u>21</u> ds.	If LESS than 1 day, hrs. or min.?
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8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<b>Steel Worker</b> <b>Bethlehem Steel Co.</b>
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9 BIRTHPLACE (State or country)	<b>Romania</b>
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10 NAME OF FATHER	<b>Abraham Ordie</b>
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11 BIRTHPLACE OF FATHER (State or country)	<b>Romania</b>
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12 MAIDEN NAME OF MOTHER	<b>Irafera Ordie</b>
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13 BIRTHPLACE OF MOTHER (State or Country)	<b>Romania</b>
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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Ordie(Address) 225, E, St Sparrows Point, Md

15 Filed <u>Nov. 28</u> 192 <u>30</u>	<u>John G. Connolly</u> Registrar
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <b>Nov. 26</b> (Month) (Day) (Year)	<b>1930</b>
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17 I HEREBY CERTIFY, That I attended the deceased from 192 <u>  </u> to 192 <u>  </u>	
--	--

that I last saw h. <u>alive on</u> <u>Investigated</u> <u>192</u>	
<u>and that death occurred on the date stated above, at</u> <u>m.</u>	
The CAUSE OF DEATH * was as follows:	

Chronic AlcoholismContributory  
Secondary

(Signed) <u>John G. Connolly</u>	(Duration) <u>  </u> yrs. <u>  </u> mos. <u>  </u> ds.
192 <u>  </u> (Address) <u>Sparrows Point</u>	

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death <u>  </u> yrs. <u>  </u> mos. <u>  </u> ds.	In the State <u>  </u> yrs. <u>  </u> mos. <u>  </u> ds.
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Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>St. Stanislaus</u>	DATE OF BURIAL <u>Nov. 29, 1930</u>
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20 UNDERTAKER <u>John G. Connolly</u>	ADDRESS <u>Essex</u>
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Mount Wilson (No. Int. Wilson Branch, Md.)  
St. Suberculosis Sanatorium Ward

Registration Dist. No. 32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Catherine Ortel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH November 25, 1902  
(Month) (Day) (Year)

7 AGE 27 yrs. 11 mos. 19 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Trained Nurse  
(b) General nature of industry, business, or establishment in which employed or (employer) (Tuberculosis)

9 BIRTHPLACE (State or country) Baltimore, Maryland

10 NAME OF FATHER Frank Smetana

11 BIRTHPLACE OF FATHER (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Bel

13 BIRTHPLACE OF MOTHER (State or country) Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Cernak  
(Address) 3537 Third St. Balto. Md.

15 Filed Nov 12 1930 W. E. Nicholas  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 11th, 1928, to Nov 13, 1930.

that I last saw her alive on November 12, 1930.

and that death occurred on the date stated above, at 12:45 A. m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis  
(Duration) 9 yrs. 9 mos. 9 ds.

Contributory  
Secondary

None  
(Duration) yrs. mos. ds.

(Signed) John A. Smith M. D.  
Nov. 12 1930 (Address) Mount Wilson, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 4 mos. 2 ds. In the 27 yrs. 11 mos. 19 ds.

Where was disease contracted, if not at place of death? (?)

Former or usual residence 710 N. Madeira St. Balto. Md.

19 PLACE OF BURIAL OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Nov 15 1930

20 UNDERTAKER Chas. P. Black ADDRESS 742 W. North Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *An accidental drowning, Struck by railway train—accidently; Testicle wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions asked in detail, it will prove a most satisfactory correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

U. S. A. DEPT. OF COMMERCE  
BUREAU OF CENSUS  
WASHINGTON, D. C.

1906

22 NOV

1906

1906

1906

1906

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Catonsville (No. Opits House)

2 FULL NAME Charles Osburn

05302

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Sept 17, 1850  
(Month) (Day) (Year)

7 AGE 79 yrs. 8 mos. 7 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER John Osburn

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Ann

13 BIRTHPLACE OF MOTHER (State or Country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Osburn  
(Address) Westminster Md

15 Filed 5/24 1930 H. Andrew Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1, 19236, to May 24, 19230  
that I last saw him alive on May 23, 19230

and that death occurred on the date stated above, at 6:30 A. m.  
The CAUSE OF DEATH \* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Senile  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Marshall B. Lamb M. D.  
May 24, 19230 (Address) Catonsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. 2 mos. \_\_\_\_ ds. In the 50 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, it not at place of death? Ind

Former or usual residence Ind

19 PLACE OF BURIAL OR REMOVAL New Oxford Pa DATE OF BURIAL May 27, 1930

20 UNDERTAKER William Cook ADDRESS 1217 S Paul



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 9 1930  
BUREAU V 8

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Bella (No. \_\_\_\_\_)

2 FULL NAME Andrew Oster

04017 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb. 2, 1850  
(Month) (Day) (Year)

7 AGE 80 yrs. 2 mos. 18 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Latimer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Eleanor Oster

(Address) Ellis City, Md.

15 Filed 4-22 1930 Baltimore  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 1, 1930 to Apr. 20, 1930

that I last saw him alive on Apr. 19, 1930

and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH \* was as follows:

Chronic Endocarditis

(Duration) 10 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) J. W. Benson M. D.

Apr. 21, 1930 (Address) Baltimore

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bella Clee DATE OF BURIAL Apr. 23, 1930

20 UNDERTAKER Easton Sons ADDRESS Ellis City

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

10173

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City Fairlawn (No. 6745) Roberts Ave St. 8 Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME still born infant (Otlowski)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)

6 DATE OF BIRTH Sept. 8<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. or — min. If LESS than 1 day, hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) M.D.

10 NAME OF FATHER Walter Otlowski

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline Noski

13 BIRTHPLACE OF MOTHER (State or Country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Pauline Otlowski

(Address) Fairlawn

15 Filed Sept 19<sup>th</sup> 1930 H. J. McConnery Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 8<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at — m. The CAUSE OF DEATH was as follows:

still born. (3 1/2 mo.)  
(Duration) — yrs. — mos. — ds.

Contributory Secondary (Duration) — yrs. — mos. — ds.  
(Signed) G. J. McConnery M. D.  
Sept 9 1930 (Address) Sparrows Point

\*State the Disease Causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sent to Johns Hopkins, 19—

20 UNDERTAKER ADDRESS

Anatomical Laboratory

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

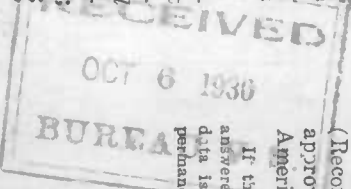
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

Village or City Catonsville Md. (No. 129)

2 FULL NAME John C Ott

04018 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH October 12, 1855  
(Month) (Day) (Year)

7 AGE 74 yrs. 5 mos. 20 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Brick maker  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Ott

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Veigant

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter J. Ott  
(Address) 234 S. Bouldin st

15 Filed 4/5 1930 H. J. Andrews Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 18, 1930, to April 2, 1930, that I last saw him alive on April 2, 1930

and that death occurred on the date stated above, at 6:45 P. M. The CAUSE OF DEATH \* was as follows:

Chronic interstitial Nephritis

Contributory Secondary arterio Sclerosis  
(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) John G. Funkh M. D.  
April 2, 1930 (Address) Catonsville Md

\*State the 1 is ase Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 15 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, it not at place of death?

Former or usual residence 234 S. Bouldin st

19 PLACE OF BURIAL OR REMOVAL Catonsville Boro. DATE OF BURIAL 4/7, 1930

20 UNDERTAKER Harry N. Witzke ADDRESS 4101 Edmondson Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

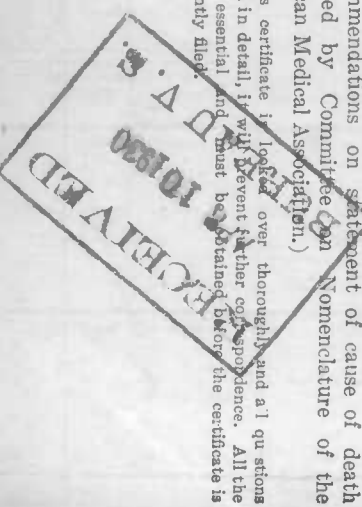
(Approved by U. S. Census and American Public  
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**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laboree," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



Pr. 24 Davis.

MARGIN RESERVED FOR BINDING 824 N. Fulton Ave.

WRITE PERMANENTLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County BaltimoreVillage or City Catonsville (No. 630 Aldershot Road

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302 FULL NAME MARY CHRISTINE OVERBECK

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH

December 19, 1855  
(Month) (Day) (Year)

7 AGE

74 yrs. 1 mos. 17 ds. or \_\_\_\_\_ min.

 If LESS than  
1 day \_\_\_\_\_ hrs.  
1 day \_\_\_\_\_ min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Baltimore Md.

10 NAME OF FATHER

George W. Becker

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Gorr

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mamie Ernest (Neice)(Address) 630 Aldershot Road15 Filed 761930

Registral

20 UNDERTAKER

Henry Sander & Sons, Inc.

ADDRESS

Baltimore St. & Broadway

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 5, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_ to \_\_\_\_\_ 192\_\_

that I last saw him alive on \_\_\_\_\_ 192\_\_

and that death occurred on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH \* was as follows:

Pneumonia Bronchi

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed)

Charles L. Mattfeldt M.D.  
Feb 6 1930 (Address) Baltimore Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryFeb. 7, 1930

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Date 26.

W. E. Adams

Doc. B. Building

Custom 8 14-2

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

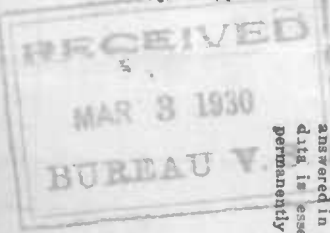
Briggs - Billings  
Hart - Feb. 5

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesenteric*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto.</u>		02662		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Catoxville 900 Edmondson St.</u>		(46)		Registration Dist. No. <u>30</u>	
2 FULL NAME <u>Dana Owens</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>May 16, 1900</u> (Month) (Day) (Year)					
7 AGE <u>29</u> yrs. <u>9</u> mos. <u>24</u> ds. or min.?		If LESS than 1 day, hrs. min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)		<u>Handsewer</u>			
9 BIRTHPLACE (State or country)		<u>Howard Co. Md</u>			
PARENTS	10 NAME OF FATHER	<u>Thomas Hall</u>			
	11 BIRTHPLACE OF FATHER (State or country)	<u>Md</u>			
	12 MAIDEN NAME OF MOTHER	<u>Mary A Scott</u>			
	13 BIRTHPLACE OF MOTHER (State or country)	<u>Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Dana Owens</u> (Address) <u>900 Edmondson</u>					
15 Filed <u>3/13</u> 19 <u>30</u>		Registrar <u>James T. House</u>			
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Mar 10th</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY That I attended the deceased from <u>Dec 1</u> to <u>Mar 10</u> , 19 <u>30</u> , that I last saw her alive on <u>March 9th</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>12:20 a.m.</u>					
The CAUSE OF DEATH * was as follows: <u>Adenocarcinoma of the Uterus</u>					
(Duration) <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds.					
Contributory <u>Menstrual - Retention</u> Secondary <u>and Uterus</u> (Duration) <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds.					
(Signed) <u>James M. Grouse</u> M. D. <u>Mar 11, 1930</u> (Address) <u>Catoxville</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
At place of death <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds. In the State <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Western Hill</u>				DATE OF BURIAL <u>3/13/30</u>	
20 UNDERTAKER <u>James T. House</u>				ADDRESS <u>578</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid housekeepers who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

APR 3 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			02663		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			(31)		Registration Dist. No. <u>93</u>	
Village or City <u>Delight</u> (No. <u>MD</u> )			St. <u>MD</u>		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Clara v. Owings (Mrs John H Owings)</u>						
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>		16 DATE OF DEATH <u>March 3 - 1930</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Sept 15 1871</u> (Month) (Day) (Year)				17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb 25 1930</u> to <u>March 3 1930</u> , that I last saw him alive on <u>March 3 1930</u> , and that death occurred on the date stated above, at <u>8 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u>		
7 AGE <u>58</u> yrs. <u>5</u> mos. <u>19</u> ds. or LESS than 1 day ____ hrs. ____ min.?				(Duration) <u>?</u> yrs. ____ mos. ____ ds.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>at home</u>				Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.		
9 BIRTHPLACE (State or country) <u>Baltimore Co Md</u>				(Signed) <u>E. E. Nicholas</u> M. D. <u>March 4 1930</u> (Address) <u>Pikesville Md</u>		
10 NAME OF FATHER <u>Andrew J. Bushey</u>				*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.		
12 MAIDEN NAME OF MOTHER <u>Mary-E: Gardner</u>				Where was disease contracted, if not at place of death?		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>				Former or usual residence		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Gladys Owings</u> (Address) <u>Kerstutson</u>				19 PLACE OF BURIAL OR REMOVAL <u>Ashbury M E Cemetery</u> DATE OF BURIAL <u>Mar 6 1930</u>		
15 Filed <u>March 3, 1930</u> <u>H. M. Slade</u> Registrar				20 UNDERTAKER <u>J F Ehrig Kerstutson Md</u> ADDRESS <u></u>		

Henry May - 1832  
H. M. (H. M. M.)

Health Association.)

approve  
Americas  
If this  
answered  
data is e  
permanent

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic nodular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was\* undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Heavily wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory," etc. (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County BaltimoreVillage or City Owings Mills (No. \_\_\_\_\_)

## 2 FULL NAME

Dorothy Pac

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

## 6 DATE OF BIRTH

March 9, 1927  
(Month) (Day) (Year)

## 7 AGE

3 yrs. 6 mos. 27 ds. or \_\_\_\_\_ min.?

## OCCUPATION

(a) Trade, profession or particular kind of work

Inmate

(b) General nature of industry business, or establishment in which employed or (employer)

Rosewood State Training School; Owings Mills, Md.

## 9 BIRTHPLACE (State or country)

Baltimore, Md.

## 10 NAME OF FATHER

Halter Pac

## 11 BIRTHPLACE OF FATHER

(State or country)

Poland.

## 12 MAIDEN NAME OF MOTHER

Catherine Mychodnick

## 13 BIRTHPLACE OF MOTHER

(State or Country)

Poland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Institutional Records  
Rosewood State Training School; Owings Mills, Md.

(Address)

15

Filed

Oct 6 1930 Attest

Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

12218

(21)

Registration Dist. No. 33

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

October 6, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 4, 1930 to Oct 6, 1930.that I last saw her alive on Oct 6, 1930,and that death occurred on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis(Duration) Unknown yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) George C. Medavay M. D.  
Oct 6 1930 (Address) Owings Mills, Md.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. 4 mos. 16 ds. In the 3 yrs. 6 mos. 27 ds. State \_\_\_\_\_Where was disease contracted, if not at place of death? UnknownFormer or usual residence Baltimore, Md.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Holy Rosary Oct 9, 1930

## 20 UNDERTAKER

## ADDRESS

F. W. Gazbowski

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

1930 Eastern Ave

Thompson Oct 6 - 1930  
Bridges

Q-16-1930

(Approved by U. S. Census and American Public Health Association.)

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is hooked over a photograph and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto</u>		08491		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Catoxville</u> (No. <u>185</u> )		St. <u>Waters An</u> Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)		Registration Dist. No. <u>30</u>	
2 FULL NAME <u>Jacob Page</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>1862</u> (Month) (Day) (Year)					
7 AGE <u>68</u> yrs. <u>0</u> mos. <u>0</u> ds. or min. If LESS than 1 day, hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Gardner</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Va</u>					
10 NAME OF FATHER <u>Jacob Page</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Va</u>					
12 MAIDEN NAME OF MOTHER <u>Jane</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Va</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Kate Page</u> (Address) <u>185 Waters An</u>					
15 Filed <u>7/23</u> 19 <u>30</u> Registrar <u>Samuel J. Hensley</u>					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 22</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>7-16</u> 19 <u>30</u> to <u>7-22</u> , 19 <u>30</u> that I last saw him alive on <u>7-21</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>2-20</u> m.					
The CAUSE OF DEATH * was as follows: <u>Terminal Broncho-pneumonia</u> <u>Decubitus colitis</u> (Duration) <u>10</u> yrs. <u>0</u> mos. <u>0</u> ds.					
Contributory Secondary (Duration) <u>10</u> yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>A. Jackson</u> M. D. <u>7-22</u> 19 <u>30</u> (Address) <u>Coon Arlington</u>					
*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For hospitals, institutions, Transients or Recent Residents) At place of death, <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the <u>0</u> state, <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>St. Auburn</u> DATE OF BURIAL <u>July 23</u> , 19 <u>30</u>					
20 UNDERTAKER <u>Samuel J. Hensley</u> ADDRESS <u>Baltimore</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, whether engaged in the duties of the household only or not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPHERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

If this certificate is filed over thoroughly and accurately answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 3 1914  
BUREAU

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

June 12 1930

B. B. Benson M.D.

Register

07182

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 37

St. Ward)

If death occurred in  
a hospital or institu-  
tion, give its NAME in-  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

Dec 30 1929, to June 10 1930.

that I last saw him alive on June 8 1930.

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH was as follows:

arteriosclerosis  
acute Regurgitation

(Duration) yrs. mos. da.

Contributory  
Secondary

(Duration) yrs. mos. da.

(Signed) B. B. Benson M.D.

June 12 1930 (Address) Eckeyville Md

\*State the Disease Causing Death, or in deaths from  
Violent Causes, state (1) Means of Injury; and (2) whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients, or Recent Residents)At place  
of death yrs. mos. da.In the  
State, yrs. mos. da.Where was disease contracted,  
if not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Hill Cemetery

June 12 1930

UNDERTAKER

ADDRESS

Frank Crach &amp; Son

1906 Oakland

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a), *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "roup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Cardioma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhausted," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERINATAL septicæmia," "PERINATAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be used for thoroughly and all questions answered here, it will need further correspondence. All questions essential must be obtained before the certificate is submitted.

RECEIVED  
JUL 11 1891

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

05303

## CERTIFICATE OF DEATH

## 1-PLACE OF DEATH

City of BALTIMORE: (No. *180* *90*) St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2-FULL NAME

(a) RESIDENCE NO. *Aberle Ave* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? *35* yrs. mos. ds.REGISTERED NO. *44*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 Color or Race *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min..

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9 BIRTHPLACE (city or town)

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (City or town)

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

## 14

Informant  
(Address)

## 15

Filed *May 18, 1930*

1930

*John E. Connolly*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17

I HEREBY CERTIFY, That I attended deceased from

*4-30-30*, to *5-17-30*, 19that I last saw him alive on *5-17-30*, 19and that death occurred, on the date stated above, at *6:30* a. m.

The CAUSE OF DEATH\* was as follows:

*Subacute Myocarditis*CONTRIBUTORY *Secondary*  
(Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of \_\_\_\_\_Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*

(Signed)

*J. H. Holla* M. D.

\*State the Disease Causing Death, or In death from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial

20 UNDERTAKER

ADDRESS

*St. Mary's Redemptor**M. W. E. Dippel Inc 37 S. Am...*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

(Approved by U. S. Census and American Public Health Asso.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms of terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if possible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

JUN 7 1900  
BUREAU V S

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		STATE OF MARYLAND	
County <u>Balto</u>		CERTIFICATE OF DEATH	
Village or City <u>Lynch's Point</u> (No. <u>North Point Rd</u> )		Registration Dist. No. <u>44</u>	
2 FULL NAME <u>Mary Panichello</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>July 9, 1904</u> (Month) (Day) (Year)			
7 AGE <u>25</u> yrs. <u>9</u> mos. <u>—</u> da. If LESS than 1 day hrs. or min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>Homework</u>			
9 BIRTHPLACE (State or country) <u>Md</u>			
PARENTS	10 NAME OF FATHER <u>Michael Chlopak</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Austria</u>		
	12 MAIDEN NAME OF MOTHER <u>Josephine Tekacy</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Austria</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank Panichello</u> (Address) <u>Lynch Point</u>			
15 Filed <u>Apr. 9, 1930</u> <u>John J. Connolly</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>April 8, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at <u>12 Noon</u> The CAUSE OF DEATH was as follows: <u>acute cardiac dilatation</u> (Duration) yrs. mos. ds.			
Contributory Secondary <u>Dr. L. N. Telleen, Spaw. Pr. Md</u> (Signed) <u>Geo. W. Carney</u> M. D. <u>4/8</u> 1920 (Address) <u>Colgate</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Vineland N. J.</u>		DATE OF BURIAL <u>4/12/1930</u>	
20 UNDERTAKER <u>John J. Connolly</u>		ADDRESS <u>Essex, Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

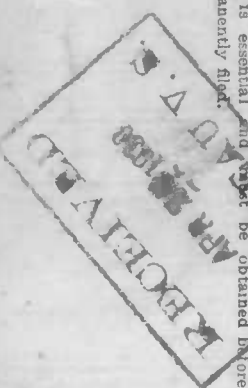
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plaster, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or, If home, Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is checked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Owings Mills (No. \_\_\_\_\_)

2 FULL NAME Gustav Paradzik

08993

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 23

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH March 26, 1843  
(Month) (Day) (Year)

7 AGE 87 yrs. 4 mos. 9 ds. or \_\_\_\_\_ min. ?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Minnie Hesson

(Address) Owings Mills, Md

15 Filed Aug 4 1930 at St. Michaels  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 4, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 16, 1930, to August 4, 1930, that I last saw him alive on August 4, 1930, and that death occurred on the date stated above, at 5 a. m. The CAUSE OF DEATH \* was as follows:

Arteriosclerosis (general)

(Duration) Unknown yrs. mos. ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. mos. ds.

(Signed) George C. Medeiros M. D.  
Aug 4, 1930. (Address) Owings Mills

\*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. mos. ds. In the State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar Hill Cemetery Aug 6, 1930

20 UNDERTAKER ADDRESS

George W Zirkler 1737 E. Egan St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E-haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

Village or City Pikeville (No. 1) Old Court Road Gray Spring Dr Ward 32  
<sup>2</sup> FULL NAME Female infant of Mrs. Mary Perin  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 18, 1930  
(Month) (Day) (Year)

7 AGE Still birth  
yrs. mos. ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X

(Address)

15 Filed Apr 19 1930 S. E. Nichols  
Registrar

04020 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 32

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Still birth (about 5 mos)  
Childs body found by Baltimore Co  
police (Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) S. E. Nichols (Duration) yrs. mos. ds. M. D.  
Apr 18 1930 (Address) Pikeville Ky

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Interment DATE OF BURIAL Apr 18, 1930

20 UNDERTAKER None ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corioma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1920  
BUREAU OF

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

2-49 13583

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Edgemoor (No.         )Demis' Flats St.          Ward         

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Cludys Parker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)         

6 DATE OF BIRTH July 15 1930  
(Month) (Day) (Year)

7 AGE 4 yrs. 2 mos. 2 ds. or, If LESS than 1 day,          hrs.          min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work infant  
(b) General nature of industry, business, or establishment in which employed or (employer)         

9 BIRTHPLACE (State or country) Md10 NAME OF FATHER John Parker11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Amanda Revine13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Parker(Address) Edgemoor15 Filed Nov 19 1930 John H. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 17 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192that I last saw him alive on 192and that death occurred on the date stated above, at 4 a m.

The CAUSE OF DEATH \* was as follows:

bilateral otitis media(Duration) 7 yrs. 2 mos. 2 ds.Contributory Secondary acute meningitis probablypneumococic (Duration) 2 yrs. 2 mos. 2 ds.(Signed) Thomas R. Brennan M. D.Nov 20 1930 (Address) Beltsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death          yrs.          mos.          ds. In the State          yrs.          mos.          ds.

Where was disease contracted, if not at place of death?

Former or usual residence         19 PLACE OF BURIAL OR REMOVAL Johns Hopkins HospDATE OF BURIAL Nov 19 193020 UNDERTAKER Joseph AhrensADDRESS 221 Buoy

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Campasitar, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (c) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *Name*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebraspinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Branchiopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Branchiopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Triæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 9 1900

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Spawans Point

2 FULL NAME Luce Paul

STATE OF MARYLAND  
CERTIFICATE OF DEATH

05305  
(89)

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH January 8, 1883  
(Month) (Day) (Year)

7 AGE 47 yrs. 4 mos. 23 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Foreman  
(b) General nature of industry, business, or establishment in which employed or (employer) Beth Steel Co

9 BIRTHPLACE (State or country) New York

10 NAME OF FATHER Frances Paul

11 BIRTHPLACE OF FATHER (State or country) New York

12 MAIDEN NAME OF MOTHER Josephine Paul

13 BIRTHPLACE OF MOTHER (State or Country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed May 31<sup>st</sup> 1930 G. F. Mc Cormick M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31<sup>st</sup>, 1930  
(Month) 5 (Day) 31 (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on \_\_\_\_\_, 192

and that death occurred on the date stated above, at 4:05 P.M.

The CAUSE OF DEATH \* was as follows:

Investigated Cause of death  
Angina Pectoris  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Jas H M Nicholas M. D.  
\_\_\_\_\_ 192 (Address)

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Trin Cathedral DATE OF BURIAL June 3, 1930

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUN 7 1930  
BUREAU

WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Monkston (No.     )

2 FULL NAME Edwin Lawrence Pearce

04021

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 39

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 ~~SINGLE~~ WIDOWER  
(Write the word)

6 DATE OF BIRTH July 24, 1863  
(Month) (Day) (Year)

7 AGE 66 yrs. 8 mos. 16 ds. or      min. ?  
If LESS than 1 day.... hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Balto Co. Md.

10 NAME OF FATHER Jacob Myers Pearce

11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Laura Holmes

13 BIRTHPLACE OF MOTHER (State or country) Balto Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Laura Pearce

(Address) Monkton Md.

15 Filed April 19, 1930 Frank A. Blake  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 19, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from      192      to      192     

that I last saw him alive on      192     

and that death occurred on the date stated above, at 8:00 A. M.

The CAUSE OF DEATH was as follows:

Heart trouble

Contributory  
Secondary

(Duration)      yrs.      mos.      da.

(Signed) Ernest W. Benson, J.P.

April 14, 1930 (Address) Rockyville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death      yrs.      mos.      da. In the State,      yrs.      mos.      da.

Where was disease contracted, if not at place of death?     

Former or usual residence,     

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. James Cemetery April 21, 1930

20 UNDERTAKER ADDRESS

Mc Brooks Son Sparks, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 8 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930  
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07727

# STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 37

 Village or City Lutherville (No.     )

 St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

 2 FULL NAME Harold Edward Pearce

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

 6 DATE OF BIRTH Oct 28, 1912  
(Month) (Day) (Year)

 7 AGE 17 yrs. 8 mos. 4 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

 8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed or (employer)

 9 BIRTHPLACE (State or country) Md

 10 NAME OF FATHER J N Pearce

 11 BIRTHPLACE OF FATHER (State or country) Md

 12 MAIDEN NAME OF MOTHER Minerva Duffen Dyer

 13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) J N Pearce  
(Address) Lutherville Md

 15 Filed July 2 1930 B R Benson Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH July 2, 1930  
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from Jan 4, 1930 to July 2, 1930  
that I last saw him alive on July 2, 1930,

 and that death occurred on the date stated above, at 334 M.  
The CAUSE OF DEATH \* was as follows:

Coronary insufficiency  
Inflammatory Rheumatism  
(Duration) 6 yrs. 6 mos.      ds.

 Contributory Secondary (Duration)      yrs.      mos.      ds.

 (Signed) B R Benson M. D.  
July 2, 1930 (Address) Cuttyhunk Ave

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Monks Cemetery July 5, 1930  
Markline + Son ADDRESS White Hall

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Sealsman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling iron—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			07728		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			(91-2)		Registration Dist. No. <u>35</u>	
Village or City <u>6515-Sherwood Road. Govans, Ind.</u>			St.		Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Joseph W. Pearce</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widower</u>				
6 DATE OF BIRTH <u>Aug 10, 1874</u> (Month) (Day) (Year)						
7 AGE <u>75 yrs. 11 mos. 16 ds.</u> If LESS than 1 day hrs. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Retired Farmer.</u>						
9 BIRTHPLACE (State or country) <u>Balto Co. Ind</u>						
10 NAME OF FATHER <u>Josiah Pearce</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Balto Co. Ind</u>						
12 MAIDEN NAME OF MOTHER <u>Elizabeth Wright</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Co. Ind</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Chas. L. Pearce</u> (Address) <u>White Hall, Ind</u>						
15 Filed <u>July 29th 1930</u> <u>M. Bortner, Jr.</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>July 26, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 1930</u> to <u>July 26, 1930</u> , that I last saw him alive on <u>July 25, 1930</u> and that death occurred on the date stated above, at <u>1059 a.m.</u> The CAUSE OF DEATH * was as follows:						
<u>Arterio Sclerosis</u>						
(Duration) <u>2</u> yrs. mos. ds.						
Contributory Secondary						
(Signed) <u>John B. Bortner</u> M. D. <u>July 26, 1930</u> (Address) <u>White Hall, Ind</u>						
State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death yrs. mos. ds. In the State yrs. mos. ds.						
Where was disease contracted, if not at place of death?						
Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>Vernon County</u>					DATE OF BURIAL <u>July 28, 1930</u>	
20 UNDERTAKER <u>P. Macklinson Son</u>					ADDRESS <u>White Hall, Ind</u>	
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.						

PARENTS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mexases; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mexases* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

02664

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 3K

Village or City

Jollevydale, Gwynn, Ind

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Frances Pearce

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)married

6 DATE OF BIRTH

Nov11887

(Month)

(Day)

(Year)

7 AGE

72 yrs.4 mos.15 ds.If LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

At Home

9 BIRTHPLACE

(State or country)

Baltimore Co.

10 NAME OF FATHER

Thomas F. Lytle

11 BIRTHPLACE OF FATHER

(State or country)

Harford Co. Ind

12 MAIDEN NAME OF MOTHER

Elmore H. Treadway

13 BIRTHPLACE OF MOTHER

(State or country)

Harford Co. Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. O. V. Street

(Address)

6515 Sherwood Road

15

Filed

Nov 71900Wm P Butler

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 30  
1900  
Nov 30 (Month) 30 (Day) 1900 (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov 30 to Nov 6, 1900, that I last saw her alive on Nov 6, 1900and that death occurred on the date stated above, at 3 P. m.  
The CAUSE OF DEATH was as follows:Paralysis(Duration) yrs. \_\_\_\_\_ mos. 3 ds.

Contributory Secondary

Cerebral Haem.

(Signed)

Wm P Butler

(Address)

Nov 6-30, 1900

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients &amp; Recent Residents)

At place of death yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Vernon CemeteryNov, 1900

20 UNDERTAKER

ADDRESS

P. Macklinson LowWhite Hall Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930  
BUREAU V. S.

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore

06500

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Glen Arm (No. Glen Arm Road St. \_\_\_\_\_ Ward \_\_\_\_\_)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah A. Pearce

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, Widowed, WIDOWED, OR DIVORCED (Write the word)
------------------------	---------------------------------	---

6 DATE OF BIRTH

May 1st, 1836  
(Month) (Day) (Year)

7 AGE

94 yrs. 1 mos. 23 ds. or min.?If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Richard G. Woods

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann Gallagher

13 BIRTHPLACE OF MOTHER (State or Country)

Philadelphia, Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas G. Pearce(Address) Glen Arm, Maryland.15 Filed 6/25 1930 G. M. Baer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 24th, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1930 to June 24th, 1930that I last saw him alive on June 24th, 1930and that death occurred on the date stated above, at 8:40 P.m.

The CAUSE OF DEATH \* was as follows:

Myocardiac Insufficiency

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
SecondarySenility, Arterio Sclerosis, Incontinence  
(Signed) David of St. Thos. Seminary M. D.  
June 15, 1930 (Address) Tanaw, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prospect Hill CemeteryJune 26, 1930

20 UNDERTAKER

ADDRESS

Fred. Lassarhut SonFullerton, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

13584

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 144

Village or City Calgate (No. Meritt Ave St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Still born infant, Pencek

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Nov 30th, 1930  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. or — min. LESS than 1 day

8 OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Emma A Pencek

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma A. Pencek

(Address) Calgate Md

15 Filed Nov. 30th 1930 G. M. Comner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 30th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192— to —, 192—

that I last saw him alive on —, 192—

and that death occurred on the date stated above, nt — m.

The CAUSE OF DEATH \* was as follows:

still born infant

Contributory Secondary Premature (Duration) — yrs. — mos. — ds.

(Signed) G. M. Comner M. D. Nov 30 1930 (Address) Spencertown

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sent to Johns Hopkins, 19—

20 UNDERTAKER ADDRESS

Anatomical Laboratory

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City near Rustertown (No. MD)

06501 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

St. MD Ward MD (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Infant son of John & Bessie Perego

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)

6 DATE OF BIRTH June 25, 1930  
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Stillborn  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto Co MD

10 NAME OF FATHER John Perego

11 BIRTHPLACE OF FATHER (State or country) MD

12 MAIDEN NAME OF MOTHER Bessie Teal

13 BIRTHPLACE OF MOTHER (State or Country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Perego  
(Address) Rustertown MD

15 Filed June 25 1930 MD  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 25th, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 6-25-1930 to 6-25-1930, 1930.

that I last saw him on 6-25-1930, 1930.

and that death occurred on the date stated above, stillborn.  
The CAUSE OF DEATH was as follows:

Stillborn

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) James J. Saffell M. D.

6-25-1930 (Address) MD

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ashbury MD Co County June 25 1930

20 UNDERTAKER ADDRESS

H. F. Oliver Rustertown MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

06502 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 07

Village or City Texas (No. 148)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Anna V Perry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH July 6 1910  
(Month) (Day) (Year)

7 AGE 19 yrs. 11 mos. 14 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Frank Egan

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Ireland

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Perry Jr  
(Address) Texas

15 Filed June 20 1930 B B Burch Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 18 1930 to June 20 1930

that I last saw him alive on June 20 1930

and that death occurred on the date stated above, at 4:00 m.  
The CAUSE OF DEATH \* was as follows:

Puerperal Eclampsia: 21 days.  
Cerebral (Duration) yrs. mos. ds.

Contributory Secondary

(Signed) B B Burch M. D.  
June 20 1930 (Address) Cockeysville

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renditer wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 7 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Balto.

14215

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City North Pt. Rd. (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME A. Peterson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)?

6 DATE OF BIRTH

?

(Month)

(Day)

(Year)

7 AGE

? about 45 yrs.

If LESS than

1 day \_\_\_\_\_ hrs.

yrs.

mos.

ds.

or \_\_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

?

10 NAME OF

FATHER

Unknown

11 BIRTHPLACE

OF FATHER

(State or country)

Unknown

12 MAIDEN NAME

OF MOTHER

Unknown

13 BIRTHPLACE

OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Strocks Stone

(Address)

North Pt. Rd.

15

Filed

Dec 2, 1930Thos. G. Connolly

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 241930

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

17

I HEREBY CERTIFY, That I attended the deceased from

\_\_\_\_\_ 192\_\_ to \_\_\_\_\_ 192\_\_.

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 192\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Struck by automobile, accidentalContributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Jacob Dallman Coroner

(Signed) \_\_\_\_\_ M.D.

\_\_\_\_\_ 192\_\_ (Address) Stammers Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Texas Abn. Home

DATE OF BURIAL

12/2/1930

20 UNDERTAKER

Thos. G. Connolly

ADDRESS

Coax

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 7 1931

BUREAU V.S.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

67729

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City Stourelleigh (No. 7104 Wardman Rd. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alma K Paterson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 29, 1891  
(Month) (Day) (Year)

7 AGE 39 yrs. 0 mos. 17 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At home  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Chicago - Ill.

10 NAME OF FATHER Hugo Krause

11 BIRTHPLACE OF FATHER (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Emma Goodgissel

13 BIRTHPLACE OF MOTHER (State or Country) Chicago - Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Tillie Peterson

(Address) 7104 Wardman Rd

15 Filed July 17, 1930 H. P. Lester Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 12, 1920 to July 15, 1930, that I last saw her alive on July 14, 1930

and that death occurred on the date stated above, at 3:30 a. m.  
The CAUSE OF DEATH \* was as follows:

Sepsis  
(Streptococcus)

(Duration) 4 yrs. 3 mos. 3 ds.  
Contributory Infected tooth  
Secondary

(Duration) 4 yrs. 3 mos. 3 ds.  
(Signed) Wm. A. Todd M. D.  
July 15, 1930 (Address) 735 N. Fulton Ave.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 3 mos. 3 ds. In the State 4 yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 7/17, 1930

20 UNDERTAKER William Cook ADDRESS 1217 St Paul



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore14717 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Stemmers Run (No.      St.      Ward     )

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alexander S. Pettit

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)6 DATE OF BIRTH Dec. 4, 1858  
(Month) (Day) (Year)7 AGE 72 yrs. 1 mos. 1 ds. or      min.?  
If LESS than 1 day... hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Printer  
(b) General nature of industry, business, or establishment in which employed or (employer) Retired9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Dr. A. T. Pettit11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Lucinda B. Stephens13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Burnett A. Pettit  
(Address) Stemmers Run15 Filed Dec. 13, 1930 Thos. G. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 11<sup>th</sup>, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct. 1, 1930 to Dec. 11, 1930.that I last saw him alive on Dec. 11, 1930and that death occurred on the date stated above, at 10:50 m.The CAUSE OF DEATH \* was as follows:  
Carcinoma of the oesophagus.about (Duration) 8 yrs.      mos.      ds.Contributory Cardiac failure probably  
Secondary due to embolus. (Duration) 1 yrs.      mos.      ds.(Signed) George H. Kump M. D.  
Dec. 12, 1930 (Address) 3030 Calmar Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence     19 PLACE OF BURIAL OR REMOVAL London Park Cemetery DATE OF BURIAL Dec. 16, 193020 UNDERTAKER Frederick Lassahn ADDRESS 740 1/2 Belair Rd.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc.*, (*Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 7 1932

BURMAN

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Baltimore

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City

Sparrows Point (No. 1112 3d.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Annie M. Pezet

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

March 5, 1861  
(Month) (Day) (Year)

7 AGE

69 yrs. 6 mos. 26 ds. If LESS than 1 day... hrs. or... min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

House

(b) General nature of industry business, or establishment in which employed or (employer)

House

9 BIRTHPLACE (State or country)

Birmingham, Del

10 NAME OF FATHER

William Pezet

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Fred S. Sinner

(Address)

1112 3d. Sparrows Pt.

15

Filed

Oct 21, 1930

G. L. McComick

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 1, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept 15, 1930 to Oct 1, 1930

that I last saw her alive on Oct 1, 1930

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH \* was as follows:

Chronic myocardial infarction

(Duration) Unknown yrs. mos. ds.

Contributory Secondary

None

(Duration) Unknown yrs. mos. ds.

(Signed) Dawson R. Farber M. D.

Oct 1, 1930 (Address) Sparrows Point, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Birmingham, Del

DATE OF BURIAL

Oct 4, 1930

20 UNDERTAKER

Th. J. Lickner, Jones

ADDRESS

Hofa, Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner*, (b) *Cotton mill*; (a) *Solemon*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU



## HEALTH DEPARTMENT—CITY OF BALTIMORE

13585

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

Balto. Co. Md. (Catonsville) REGISTERED NO. 30

CITY OF BALTIMORE: (No. 38 Overbrook Road

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2-FULL NAME Juliana Elisabeth Pfeffer

Balto. Co. Md. (Catonsville)

(a) RESIDENCE. No. 38 Overbrook Road

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 69

yrs.

mos.

ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Simon Pfeffer

## 6 DATE OF BIRTH (month, day, and year)

7/16/1843

## 7 AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.

87

2

1

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work

Retired

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

House-work.

(c) Name of employer

9 BIRTHPLACE (city or town)  
(State or country)Langd  
Germany

## 10 NAME OF FATHER

Jacob Schaefer

## 11 BIRTHPLACE OF FATHER (city or town)

Langd

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Juliana Zimmer. Nov. 18/30 (Address) 933 Hanover st. Balto.

## 13 BIRTHPLACE OF MOTHER (city or town)

Langd

(State or country)

Germany

## 14

Informant  
(Address)Edward Pfeffer  
38 Overbrook Road

## 15

Filed

11/17, 1930

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year) Nov. 17/30/ 19

## 17

I HEREBY CERTIFY, That I attended deceased from

Nov. 11/30, 19, to Nov. 17/30, 19,

that I last saw her alive on Nov. 17/30, 19,

and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia.

(duration) \_\_\_\_ yrs. \_\_\_\_ mos. 6 ds.

CONTRIBUTORY  
(Secondary)

Arterio-Sclerosis.

(duration) 20 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## 18 Where was disease contracted

If not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

None.

(Signed)

C. W. Peters, M. D.

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR REMOVAL

## DATE OF BURIAL

Lombard St. Cemetery

11/20/30

## 20 UNDERTAKER

## ADDRESS

Geo. Leimbach 3214 N. Broadway

ST

MARGIN RESERVED FOR BINDING  
N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

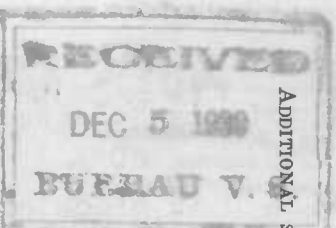
[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death)*, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		13586		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Glen Arm Md.</u> (No. _____)		St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John Maurice Phillips</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>February 9</u> , 1895 (Month) (Day) (Year)					
7 AGE <u>35</u> yrs. <u>8</u> mos. <u>22</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>Farmer</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS					
10 NAME OF FATHER <u>John W. Phillips</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>					
12 MAIDEN NAME OF MOTHER <u>Lillie B. Miller</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Tennessee</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank E. Phillips</u> (Address) <u>Long Green Md.</u>					
15 Filed <u>Nov. 3</u> 192 <u>8</u> <u>J. H. H. H. H. H.</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov 10</u> , 192 <u>8</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the decedent from <u>Oct 28</u> , 192 <u>8</u> to <u>Oct 31</u> , 192 <u>8</u> , that I last saw him alive on <u>Nov 1</u> , 192 <u>8</u> , and that death occurred on the date stated above, at <u>7:45 a.</u> m.					
The CAUSE OF DEATH * was as follows: <u>Lobar Pneumonia</u> (Duration) _____ yrs. _____ mos. <u>4</u> ds.					
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>J. H. H. H. H.</u> M. D. <u>11/2</u> 192 <u>8</u> (Address) <u>Baltimore</u>					
*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Wilson M. E. Church Cemetery</u> DATE OF BURIAL <u>Nov 5<sup>th</sup></u> , 192 <u>8</u>					
20 UNDERTAKER <u>John E. Slade</u> ADDRESS <u>Long Green Md.</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic vesicular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 4 1930

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1 PLACE OF DEATH  
County Baltimore

67730

74-a

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 172

Village or City Haltershe (No. Oakland Road) St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Phillips

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Unknown, 1882  
(Month) (Day) (Year)

7 AGE 48 yrs. Unknown mos. Unknown ds. or Unknown min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer) Farming

9 BIRTHPLACE (State or country) North Carolina

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Phillips  
(Address) Haltershe Rd.

15 Filed July 30 1930 DeFroeffe Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 14, 1930 to July 14, 1930  
that I last saw him alive on July 14, 1930

and that death occurred on the date stated above, at 1 P.M.  
The CAUSE OF DEATH \* was as follows: E.S.T.

Cerebral Hemorrhage, Apoplexy.  
(Duration) 1 ds.

Contributory Secondary High Blood Pressure  
(Duration) 1 yrs. 1 mos. 1 ds.  
(Signed) Edw. J. Stinson M. D.

July 14, 1930 (Address) Haltershe Rd.  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death Unknown yrs. Unknown mos. Unknown ds. In the State Unknown yrs. Unknown mos. Unknown ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Int Auburn Cem DATE OF BURIAL 7-17-, 1930

20 UNDERTAKER Joe M. Skinned ADDRESS 1628 E. Madison



RECEIVED JUL 28 1930  
BUREAU V. S.

28

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto

Village or City Delight (No. 111)

2 FULL NAME John T. Pierce

10174 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 33

St. 111 Ward 111 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 22, 1882  
(Month) (Day) (Year)

7 AGE 38 yrs. 1 mos. 3 ds. or LESS than 1 day 0 hrs. 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Warfield Pierce

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Tracy

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Amelia Pierce  
(Address) Reisterstown Md

15 Filed Sept 26, 1920 H. M. Slade  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25<sup>th</sup>, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1920 to 1920, 1920

that I last saw him alive on 1920, 1920

and that death occurred on the date stated above, at 9 a m.

The CAUSE OF DEATH \* was as follows:

clear case of suicide  
shot himself in the left breast with a double-  
barrel shotgun, dying immediately.  
(Duration) 0 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) Robert H. LaPorte M. D.  
Sept 26, 1920 (Address) Glyndon Md Corcoran

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Druid Ridge Cemetery Sept 29, 1920

20 UNDERTAKER

ADDRESS

J. F. Eline Reisterstown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases, resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as, fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 1930

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Balto.  
Village or City Towson (No. Chesapeake & Delaware St.; Ward) 08492  
2 FULL NAME Bernard Joseph Plageman (151)  
Registration Dist. No. 38 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH November 9, 1859  
(Month) (Day) (Year)

7 AGE 70 yrs. 8 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) Laboring

9 BIRTHPLACE (State or country) Richmond Va.

10 NAME OF FATHER Bernard Plageman

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Renke

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Annie B. Plageman

(Address) Towson Md

15 Filed Aug 1, 1930 W. P. Butler REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to July 31, 1930,  
that I last saw him alive on July 30, 1930.

and that death occurred on the date stated above, at 5 A m.

The CAUSE OF DEATH\* was as follows:  
Gangrene of foot & hand

(Duration) 3 yrs. 3 mos. 3 ds.  
Contributory General debility  
Secondary

(Duration) 2 yrs. 7 mos. 7 ds.

(Signed) E. M. Duncan, M. D.  
July 31, 1930. (Address) 5106 York Road

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted — — —

If not at place of death? — — —  
Former or usual residence — — —

19 PLACE OF BURIAL OR REMOVAL Solih Redemer - Balto Md DATE OF BURIAL Aug 7, 1930

20 UNDERTAKER Stewart Menns ADDRESS Balto

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-themia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





MARGIN RESERVED FOR BINDING

WRITE IN INK ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore

13587

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 39

Village or City Monkton (No. \_\_\_\_\_)

St: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elizabeth Jenkins Pleasants

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH January 29 1840  
(Month) (Day) (Year)

7 AGE 91 yrs. 9 mos. 7 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Jenkins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lydia Armour

13 BIRTHPLACE OF MOTHER (State or country) Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Joseph Sparks  
(Address) Monkton, Md.

15 Filed 11-7- 1930 Francis A. Blake Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 6 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1 1930 to Nov 6 1930 that I last saw him alive on Nov 5 1930 and that death occurred on the date stated above, at 5 P in.

The CAUSE OF DEATH \* was as follows:

Chronic interstitial nephritis

(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

(Signed) R. R. Shuman M. D.  
Nov 7 1930 (Address) Sparks, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds. In the State \_\_\_\_ yrs \_\_\_\_ mos \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St Johns Cemetery DATE OF BURIAL Nov. 8, 1930

20 UNDERTAKER M. C. Brooks & Son ADDRESS Sparks, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "labore", "Foreman", "Manager", "Teamster", etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia. Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Broncho pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 3 1913  
BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City

White Hall, Ind.

2 FULL NAME

Jesse Pocock

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

July 11, 1845  
(Month) (Day) (Year)

7 AGE

85 yrs. 1 mos. 9 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Retired Farmer

9 BIRTHPLACE

(State or country)

Balto. Co. Ind.

10 NAME OF FATHER

John Pocock

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

May Ellen Hendrix

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lora B. Cooley

J. P. Gennison

White Hall, Ind.

15

Filed

Aug 21

1930

M. Portier M.D.

Registrar

08994

(118-6)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 31

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 20, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Aug 15, 1930 to Aug 20, 1930

that I last saw him alive on Aug 19, 1930

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH \* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 4 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Miner Boston M. D.

Aug 21, 1930 (Address) White Hall Ind.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel City,

Aug 22, 1930

20 UNDERTAKER

ADDRESS

P. Macklinson

White Hall Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary, may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Reisterstown (No. 31)

2 FULL NAME Daniel Hotskin

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. B 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH December 18, 1903  
(Month) (Day) (Year)

7 AGE 26 yrs. 3 mos. 21 ds. If LESS than 1 day... hrs. or... min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work clerk  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER Joseph Hotskin

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Sadie Kestie

13 BIRTHPLACE OF MOTHER (State or Country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert F. Shrier  
(Address) MT Pleasant, Reisterstown

15 Filed April 8, 1930 Dr. Hotskin  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8<sup>th</sup>, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 21, 1930 to April 8<sup>th</sup>, 1930.

that I last saw him alive on April 8<sup>th</sup>, 1930.

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH \* was as follows:  
Primary tuberculosis

(Duration) 18 ds.

Contributory  
Secondary

(Duration) 18 ds.

(Signed) Albert F. Shrier M. D.  
April 8<sup>th</sup>, 1930 (Address) MT Pleasant Reisterstown

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 18 ds. In the 2 yrs. 18 mos. 18 ds.

Where was disease contracted, Baltimore  
if not at place of death?

Former or usual residence 3902 Green Spring Ave

19 PLACE OF BURIAL OR REMOVAL Hebrew Cem DATE OF BURIAL April 9, 1930

20 UNDERTAKER Jack Lewis ADDRESS 14396 Baltimore



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently ind.

RECEIVED  
JUN 16 1930

*James P. ...*  
*Apr 8 1930*  
*Medical DE*

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Halsethorpe (No. 51)

2 FULL NAME Rosa Poggi

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 12, 1918  
(Month) (Day) (Year)

7 AGE 72 yrs. 1 mos. 15 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Washington D.C.

10 NAME OF FATHER Gabriel Poggi

11 BIRTHPLACE OF FATHER (State or country) Italy

12 MAIDEN NAME OF MOTHER Julia Bacigalupa

13 BIRTHPLACE OF MOTHER (State or Country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Knecht  
(Address) Woodside Ave Halsethorpe

15 File Aug 28 1930 De Muffee Registrar

08995

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

St. Ind Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 27, 1930  
(Month) 27 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 10, 1930 to August 27, 1930, that I last saw her alive on August 27, 1930,

and that death occurred on the date stated above, at 11:17 m. The CAUSE OF DEATH \* was as follows:

Diabetes Mellitus

(Duration) 6 months

Contributory  
Secondary

Senility

(Duration) Yrs mos ds

(Signed) Joseph L. Valentine M. D.  
Aug 27 1930 (Address) 14 So Broadway

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs mos ds In the State yrs mos ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral DATE OF BURIAL Aug 30, 1930

20 UNDERTAKER Frank V. Pappitona ADDRESS 2818 E. 13th St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by tartaric acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is permanently filed.

SEP 5 1930  
BUREAU

MARGIN RESERVED FOR BINDING  
WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.14718 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Edgemere (No. Spawns Pt. Rd. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2 FULL NAME Catherine Poist

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)6 DATE OF BIRTH Sept. 16th, 1890  
(Month) (Day) (Year)7 AGE 40 yrs. 2 mos. 24 ds. or min. If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Penna.10 NAME OF FATHER Fred. C. Schlimme11 BIRTHPLACE OF FATHER (State or country) Penna.12 MAIDEN NAME OF MOTHER Emma Klinger13 BIRTHPLACE OF MOTHER (State or Country) Penna.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel B. Poist(Address) Box 132 Rt #10 Edgemere15 Filed Dec 12 1930 John G. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 10, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 26 192 to Dec 9, 1930, that I last saw her alive on Dec 9, 1930and that death occurred on the date stated above, at 6 A. M.  
The CAUSE OF DEATH \* was as follows:Carcinoma of Cervix(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory Secondary None

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Dawson L. Barber M. D.  
Dec 11, 1930 (Address) Spawns Point Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn DATE OF BURIAL 12/12/193020 UNDERTAKER John G. Connolly ADDRESS Essex

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Coal engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 7 1931

BUREAU V. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Lodge Forest

2 FULL NAME still born infant (Porklis)

08996  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Aug 15<sup>TH</sup>, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or, If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Joseph Porklis

11 BIRTHPLACE OF FATHER (State or country) Litvania

12 M maiden NAME OF MOTHER Annie Zukowski

13 BIRTHPLACE OF MOTHER (State or Country) Litvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Porklis

(Address) Lodge Forest

15 File Aug 16 1930 G. H. McConner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 15, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192 to \_\_\_\_\_ 192,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 192,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

still born.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) G. H. McConner M. D.  
Aug 16 1930 Address Sparrowsburg

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sent to John Hopkins, 1930

20 UNDERTAKER ADDRESS

Anatomical Laboratory

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probable such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 6 1930

BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Balto.

13588

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

44

Village or City

Chesaco Park

(No.)

15th Dist.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

George C. Pollheim

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)married

6 DATE OF BIRTH

march 19th, 1907  
(Month) (Day) (Year)

7 AGE

23 yrs. 7 mos. 15 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed or (employer)

Bakery Truck

9 BIRTHPLACE

(State or country)

Balto. Md.

10 NAME OF FATHER

George J. Pollheim

11 BIRTHPLACE OF FATHER

(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Mary E. Brooker

13 BIRTHPLACE OF MOTHER

(State or Country)

Balto, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph G. Pollheim

(Address)

713 N. Milton Ave.

15 Filed

Nov. 719230John G. Connolly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 4th, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192that I last saw h. alive on 192and that death occurred on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH \* was as follows:

Struck by Penn. R. R. Train  
# 176; unavoidable accident

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Jacob Wallman Croner M. D.11/4/30 (Address) Stammers Run

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto. CemeteryNov. 8, 1930

20 UNDERTAKER

ADDRESS

John G. ConnollyEssex

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE

ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Ellicott City No. Westchester Ave.

2 FULL NAME Ruth Ann Pond

12220 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. 17, 1849  
(Month) (Day) (Year)

7 AGE 80 yrs. 11 mos. 30 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Domestic Duties  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wanson Franklin

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth Welch

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. P. Pond  
(Address) Ellicott City Md.

15 Filed 11/17 1930 W. S. S. S. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 15, 1930 19230  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 1 19230 to Oct. 15 19230  
that I last saw hu alive on Oct. 15 19230

and that death occurred on the date stated above, at 11:59 p.m.  
The CAUSE OF DEATH \* was as follows:

Senile Dementia  
(Duration) 1 yrs. 1 mos. 1 da.

Contributory Secondary Spinal Hypertrophy  
(Duration) 1 yrs. 1 mos. 1 da.

(Signed) Frank O. Miller M. D.  
Oct. 16 19230 (Address) Ellicott City Md.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Morgan Chapel Cem. DATE OF BURIAL Oct. 18, 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

NOV 5 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07731

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 44Village or City Spawns Pt. Md.St. 6249 St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Bernice Poole

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 24 COLOR OR RACE col5 SINGLE, ☒ MARRIED, ☐ WIDOWED, ☐ OR DIVORCED (Write the word)6 DATE OF BIRTH Sept 14, 1928

(Month)

(Day)

(Year)

7 AGE 10

1 yrs.

mos. 17

ds.

If LESS than 1 day... hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ms.10 NAME OF FATHER Townsend Poole11 BIRTHPLACE OF FATHER (State or country) Va12 MAIDEN NAME OF MOTHER Daisy Mason13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Townsend Poole, father(Address) 6249 St.

15

File Aug 10, 1930

3

4 McGowan

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 30 to July 31, 1930that I last saw him alive on July 30, 1930and that death occurred on the date stated above, at 5:10 P.

The CAUSE OF DEATH \* was as follows:

Broncho-pneumonia

(Duration)

yrs.

mos.

ds. 7

Contributory Secondary

(Duration)

yrs.

mos.

ds.

(Signed) J. H. Thomas

M. D.

7/31/30 (Address) 1012 9th St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ashbury CemeteryDATE OF BURIAL 8-2-, 193020 UNDERTAKER Sam'l ChaseADDRESS 1400 Mesher

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plunker, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer. Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state, occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH  
County Balto

Village or City Sparks Pt. Md

2 FULL NAME Stillborn (unnamed) Poole

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♂ 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ---

6 DATE OF BIRTH 11/3/30 (Month) (Day) (Year)

7 AGE --- yrs. --- mos. --- ds. or --- min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed or employer ---

9 BIRTHPLACE (State or country) ---

10 NAME OF FATHER Josiah Poole

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Daisy D. Poole

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josiah Poole Father

(Address) 6249 N. Sparks Pt. Md

15 Filed Nov 4<sup>th</sup> 19230 S. H. McConica Registrar

13589

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11/3/30 192---  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 11/3/30 to --- 192---  
that I last saw him alive on 11/3/30 192---  
and that death occurred on the date stated above, at --- m.  
The CAUSE OF DEATH \* was as follows: Stillborn

Contributory  
Secondary

(Duration) --- yrs. --- mos. --- ds.  
(Signed) J. H. Thomas M. D.  
11/3/30 (Address) 1110 F St NW  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death --- yrs. --- mos. --- ds. In the State --- yrs. --- mos. --- ds.

Where was disease contracted, if not at place of death?

Former or usual residence ---

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury Cemetery

Nov. 4, 1930

20 UNDERTAKER

ADDRESS

S. H. Chase & Son

1400 Madison St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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DEC-5 1930



## HEALTH DEPARTMENT—CITY OF BALTIMORE

05304

## CERTIFICATE OF DEATH (129)

## 1—PLACE OF DEATH

County Baltimore  
CITY OF BALTIMORE: (No. Baltimore ST.,        WARD)REGISTERED NO. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2—FULL NAME

Elizabeth Page

## (a) RESIDENCE NO.

(Usual place of abode)

Cuninghame St.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

## 5 Single, Married, Widowed, or Divorced, (write the word)

WidowIf married, widowed, or divorced  
HUSBAND of  
(or) WIFE of Widow

## 6 DATE OF BIRTH (month, day, and year)

March 24th 1854

## 7 AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.86 yr724

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

Self

## 9 BIRTHPLACE (city or town, State or country)

Baltimore Md.

## 10 NAME OF FATHER

Geo. Kuehl

## 11 BIRTHPLACE OF FATHER (city or town, State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Don't know

## 13 BIRTHPLACE OF MOTHER (city or town, State or country)

Don't know

## 14

Informant

(Address)

Elizabeth Kelley  
3411 St. Ambrose Ave Bk

## 15

Filed

May 20, 19 21 74 in State

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH (month, day, and year)

May 20th 1921

## 17

I HEREBY CERTIFY, That I attended deceased from

May 19th, 1920, to May 20th, 1921,that I last saw her alive on May 19th, 1920.and that death occurred, on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH was as follows:

Acute Dilatation of Heart  
Chronic coronary thrombosis(duration) X yrs. X mos. X ds.

## CONTRIBUTORY (Secondary)

Chronic Pancreatic Thrombosis(duration) X yrs. 6 mos. X ds.

## 18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of       Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank J. Miller M.D.(Address) Baltimore Md

\*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

## 19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Union Cathedral

## DATE OF BURIAL

5/23/21

## 20 UNDERTAKER

Dr. Leo Cook

## ADDRESS

Baltimore Md  
241

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

# REVISED UNITED STATES STANDARD CERTIFICATE OF CAUSE OF DEATH

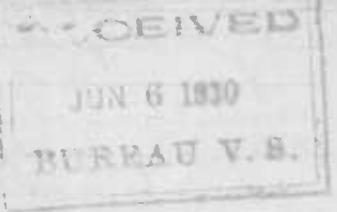
[Approved by U. S. Census and American Public Health Assn.]

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**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . (name origin

"Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As theia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN



N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			6202		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			9		Registration Dist. No. <u>41</u>	
Village or City <u>Turner Station</u> (No. <u>Balmer P.O.</u> )			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Willie Marie Pope</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>July 5, 1928</u> (Month) (Day) (Year)						
7 AGE <u>1</u> yrs. <u>6</u> mos. <u>22</u> ds. If LESS than 1 day ____ hrs. or ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>none</u>						
9 BIRTHPLACE (State or country) <u>North Carolina</u>						
10 NAME OF FATHER <u>Preston Pope</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>						
12 MAIDEN NAME OF MOTHER <u>Sarah Ann Armwood</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>North Carolina</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Preston P. Pope</u> (Address) <u>same as above</u>						
Filed <u>1/27/30</u> <u>Wm. Leamone</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Jan 27, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 17, 1930</u> to <u>Jan 21, 1930</u> , that I last saw her alive on <u>Jan 21, 1930</u> , and that death occurred on the date stated above, at <u>5:30 A.</u> m. The CAUSE OF DEATH * was as follows: <u>Pertussis (whooping cough)</u>						
Contributory Secondary <u>2 weeks</u> (Duration) yrs. ____ mos. ____ ds. <u>Broncho-pneumonia</u> <u>2 days</u> (Duration) yrs. ____ mos. ____ ds. (Signed) <u>John W. Hollis</u> M. D. <u>Jan 27, 1930</u> (Address) <u>Sparrow Point</u>						
*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Ashbury Cemetery</u>					DATE OF BURIAL <u>Jan 28, 1930</u>	
20 UNDERTAKER <u>Mrs. R. G. Elbert</u>					ADDRESS <u>1775 Ashland Ave</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 3 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day, hrs.  
yrs. mos. ds. or min.?

## OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

April 6<sup>th</sup> 1923

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 8 A m.

The CAUSE OF DEATH was as follows:

still born infant (5 mo)

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

M. D.

April 6 1923 (Address) Sparrows Point

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sent to Johns Hopkins , 19

20 UNDERTAKER

ADDRESS

Anatomical Laboratory



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pigsticker, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Broncho-pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PROMPTLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Edgemere (No. Edgemere Road)

2 FULL NAME John Porter

12221 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 44

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M

6 DATE OF BIRTH Jan 5 1891  
(Month) (Day) (Year)

7 AGE 39 yrs. 9 mos. 10 ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Labourer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Va

10 NAME OF FATHER John R. Porter

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Fred Porter  
(Address) Edgemere Road

15 Filed Dec 15 1923 W. H. McManis M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10/15/1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 10/10/30 192 to 10/15/30 192

that I last saw him alive on 10/13/30 192

and that death occurred on the date stated above, at 9 A m.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. H. Thomas M. D.  
10/15/20 (Address) 2012 30th Street N.W.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Old Tomb Va DATE OF BURIAL Oct 17 1920

20 UNDERTAKER Wm H. Chase & Son ADDRESS 1400 Washer

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Shoemaker, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report more symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

NOV 8 1930  
BUREAU V. 8

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

07732 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City EUDOWOOD SANATORIUM, TOWSON, MD

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Ellen Ross

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 14 1906  
(Month) (Day) (Year)

7 AGE 24 yrs. 2 mos. 21 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Student  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Rockville, Md.

10 NAME OF FATHER Bernard Ross

11 BIRTHPLACE OF FATHER (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Mary Elizabeth Tall

13 BIRTHPLACE OF MOTHER (State or Country) Frederick, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records--Personal History  
(Informant)  
Eudowood Sanatorium, Towson, Md.  
(Address)

15 Filed July 7 1930 Wm P Butler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 5 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 29 1929 to July 5 1930, that I last saw her alive on July 5 1930, and that death occurred on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH \* was as follows: Acute Cordial Dilatation

Contributory Secondary Pulmonary Tuberculosis  
(Duration) yrs. mos. ds.

(Signed) W A Bridges M. D.  
1930 (Address) Towson, Maryland

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockville Md DATE OF BURIAL July 8 1930

20 UNDERTAKER Roy W Barber ADDRESS Patheburg Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Coal engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			04024		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sturtevant</u> (No. <u>Mar Rogers State</u> )			Registration Dist. No. <u>32</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Ella Post</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>				
6 DATE OF BIRTH <u>March 13</u> , 18 <u>45</u> (Month) (Day) (Year)						
7 AGE <u>85</u> yrs. <u>0</u> mos. <u>25</u> ds. or <u>LESS</u> than 1 day <u>hrs.</u> or <u>min.</u>						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer)						
9 BIRTHPLACE (State or country) <u>Baltimore Md</u>						
10 NAME OF FATHER <u>Alexander Hamilton Sturtevant</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>						
12 MAIDEN NAME OF MOTHER <u>Elizabeth Gibson Bordley</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>A. H. S. Post</u> (Address) <u>Sturtevant Md</u>						
15 Filed <u>Mar 8</u> 19 <u>30</u> <u>A. H. S. Post</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>April 7</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>Several yrs.</u> 19 <u>20</u> to <u>April 7</u> , 19 <u>30</u> , that I last saw her alive on <u>April 6</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>9:45 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Myocarditis</u>						
Contributory Secondary (Duration) <u>10</u> yrs. <u>0</u> mos. <u>0</u> ds. <u>Semility</u>						
Signed) <u>E. C. Nichols</u> M. D. <u>April 7</u> 19 <u>30</u> . (Address) <u>Pikesville Md.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>7</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>7</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death?						
Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>St Thomas. Cem. - Forest</u>						DATE OF BURIAL <u>4/9-</u> , 19 <u>30</u>
20 UNDERTAKER <u>Henry W. Jenkins Sons Co</u>						ADDRESS <u>Orchard</u> <u>McCullough</u>

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Baltimore05306 STATE OF MARYLAND  
CERTIFICATE OF DEATH

(129)

Registration Dist. No. 31Village or City Stoneleigh (No. 605 Kingston Road)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Ellen Potter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <b>Female</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <b>Single</b>
------------------------	---------------------------------	--

6 DATE OF BIRTH  
October 29, 1863  
(Month) (Day) (Year)

7 AGE  
66 yrs. 5 mos. 4 ds. or 1 day 1 hrs. 1 min.  
IF LESS than

8 OCCUPATION  
(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)  
Pennsylvania

10 NAME OF FATHER  
Hiram M. Potter

11 BIRTHPLACE OF FATHER  
(State or country)  
Pennsylvania

12 MAIDEN NAME OF MOTHER  
Suzanne Miller

13 BIRTHPLACE OF MOTHER  
(State or country)  
Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Retta E. Harp(Address) 605 Kingston Road

15 Filed May 5 1920 W. P. B. B. B.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 5 1920 to May 3 1920

that I last saw him alive on May 3, 1920

and that death occurred on the date stated above, at 11:25 A. M.

The CAUSE OF DEATH \* was as follows:

Arturoschm's d. of night,  
d. Myocarditis  
Paralysis agitans

(Duration) 6 yrs. 5 mos. 4 ds.

Contributory  
Secondary

Trauma

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) D. W. Bishop M. D.

May 5 1920 (Address) 551 Shandon

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 5 mos. 4 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parkwood Cemetery May 5, 1930

20 UNDERTAKER

ADDRESS

Henry W. McLean & Son 805 W. Calver St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Baltimore

01414

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

Village or City Arbutus (No. Poplar Ave.)

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Frank B. Potterfield,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH October 18, 1862  
(Month) (Day) (Year)

7 AGE 67 yrs. 3 mos. 24 ds. IF LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Produce Dealer  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Knoxville Md.

10 NAME OF FATHER John D. Potterfield,

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A. Jenkins,

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Clara E. Potterfield  
(Address) Poplar Av. Arbutus

15 Filed Feb 13 1930 Geo W Little  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH FEB 12 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 6 1929 to Feb 12 1930,  
that I last saw him alive on Feb 11 1930,  
and that death occurred on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. 6 mos. 6 ds.  
Contributory Benign Hypertrophied Prostate  
Secondary

(Duration) 2 yrs. 2 mos. 2 ds.  
(Signed) W. B. Pearson M. D.  
2/12 1930 (Address) Hall Street and

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL St O Live Cem FEB 14 1930

20 UNDERTAKER Geo W Little  
ADDRESS 900 EDMONDSON AVE.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A like data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		02665 STATE OF MARYLAND	
County <u>Balto</u>		CERTIFICATE OF DEATH	
Village or City <u>Crown Hill</u> (No. <u>32</u> )		Registration Dist. No. <u>33</u>	
2 FULL NAME <u>Anna Powell</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write "Married" or "Single") <u>Married</u>	
6 DATE OF BIRTH <u>Aug 1910</u> (Month) (Day) (Year)			
7 AGE <u>20</u> yrs. <u>7</u> mos. <u>1</u> day <u>19</u> hrs. <u>45</u> min. (If LESS than 1 day)			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Md</u>			
10 NAME OF FATHER <u>unknown</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>			
12 MAIDEN NAME OF MOTHER <u>Helen Powell</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Bennett</u> (Address) <u>32 Maine St</u>			
15 Filed <u>3/17/30</u> <u>Thos. H. Harrison</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>March 16, 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>3-11-1930</u> to <u>3-16-1930</u> , that I last saw her alive on <u>3-16-1930</u> and that death occurred on the date stated above, at <u>8:30 p.m.</u> The CAUSE OF DEATH was as follows: <u>Infant pneumonia</u> (Duration) <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds.			
Contributory Secondary (Signed) <u>R. L. Jackson M.D.</u> <u>2/17/30</u> (Address) <u>6004 Ardmore</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. In the State <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Western Steeple</u>		DATE OF BURIAL <u>3-17-1930</u>	
20 UNDERTAKER <u>James E. Ertong</u>		ADDRESS <u>816 Pa Ave</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonæum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Brochopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphænia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 3 1904  
BUREAU

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore07156 STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 28Village or City EUDOWOOD SANATORIUM, TOWSON, MD.St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Pauline Towson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH  
July 4, 1901  
(Month) (Day) (Year)7 AGE  
28 yrs. 0 mos. 29 ds. or min.?  
If LESS than 1 day hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE  
(State or country) York Pa.10 NAME OF FATHER Clayton Bellinger11 BIRTHPLACE OF FATHER  
(State or country) York, Pa.12 MAIDEN NAME OF MOTHER Rosa Tracy13 BIRTHPLACE OF MOTHER York, Pa.14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Hospital Records--Personal History

(Informant)

Eudowood Sanatorium, Towson, Md.

(Address)

15 Filed June 4, 1930 W. P. Blythe  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
June 3, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
May 20, 1930 to June 3, 1930,  
that I last saw her alive on June 3, 1930,  
and that death occurred on the date stated above, at 9:05 A.M.  
The CAUSE OF DEATH \* was as follows:Pulm. Tuberculosis(Duration) 2 yrs. mos. ds.Contributory  
Secondary(Signed) W. G. Bridges M. D.  
1930 (Address) Towson, Maryland.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 14 ds. In the unknown State yrs. mos. ds.Where was disease contracted, if not at place of death? UnknownFormer or usual residence 2647. Bernard St. Balto.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Jerome Cem. Calverton June 5, 1930

20 UNDERTAKER ADDRESS

Wm. C. Doolan & Son Sparks, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If recited from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Lutherville (No. \_\_\_\_\_)

2 FULL NAME Flora McKay Powers

02666

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 38

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Feb 2, 1848  
(Month) (Day) (Year)

7 AGE 82 yrs. 1 mos. 19 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) North Scotia

10 NAME OF FATHER Donald McKay

11 BIRTHPLACE OF FATHER (State or country) North Scotia

12 MAIDEN NAME OF MOTHER Anna MacFarlane

13 BIRTHPLACE OF MOTHER (State or Country) North Scotia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben Wm Robinson

(Address) Lutherville and

15 Filed March 30, 1930 Am P. Butler  
dep Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 12, 1930 to March 20, 1930, that I last saw her alive on March 20, 1930,

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH \* was as follows: Carcinoma - (uterine)

Contributory Secondary \_\_\_\_\_

(Duration) 3 yrs. - mos. - ds.  
(Signed) Christine A. M. D.  
March 21, 1930 (Address) Lutherville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Prospect Hill DATE OF BURIAL Mar. 22, 1930

20 UNDERTAKER John Burns Sons ADDRESS Towson.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Baltimore

04025

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

H H

Village or City

Harron Point (No. 705 F.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

George F Powers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE,

MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Feb 10 1867  
(Month) (Day) (Year)

7 AGE

63 yrs. 2 mos. 16 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Cabin Work at

(b) General nature of industry, business, or establishment in which employed or (employer)

Bethlehem Steel

9 BIRTHPLACE

(State or country)

Washington D.C.

10 NAME OF FATHER

Mathews Powers

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Apr. 29 1923 G. H. McCormick, Jr. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 26 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 2 - 1923 to April 26, 1923, that I last saw him alive on April 25, 1923, and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH \* was as follows:

Arterio-sclerotic & Chronic myocarditis  
(Duration) 10 mos. ds.  
Contributory  
Secondary Cerebral hemorrhage  
(Duration) 3 yrs. 3 mos. ds.

(Signed) Dawson L. Parker M. D.  
April 26, 1923 (Address) Harron Point Md

\*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn

April 30, 1923

20 UNDERTAKER

ADDRESS

John F. Denny 715 2 15 St SE

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E-haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1920  
BURMA

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>			06503		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sparks</u> (No. _____)			St. _____ Ward _____		Registration Dist. No. <u>37</u>	
2 FULL NAME <u>Louis Basm Price</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>May 13, 1884</u> (Month) (Day) (Year)						
7 AGE <u>46</u> yrs. <u>1</u> mos. <u>10</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farm</u> (b) General nature of industry business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Baltimore</u>						
10 NAME OF FATHER <u>Emory Price</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore</u>						
12 MAIDEN NAME OF MOTHER <u>Ellen Price</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Baltimore</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Franklin Price</u> (Address) <u>Sparks Ind</u>						
15 Filed <u>June 25, 1930</u> <u>B. R. Bennett</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>June 23, 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 1929</u> to <u>June 1930</u> that I last saw him alive on <u>June 10, 1930</u> , and that death occurred on the date stated above, at <u>12</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic heart disease</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Acute dilatation</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>R. W. Shuman</u> M. D. <u>June 24, 1930</u> (Address) <u>Sparks Ind</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Jesus's Cemetery</u>					DATE OF BURIAL <u>June 25, 1930</u>	
20 UNDERTAKER <u>Wm. C. Burr</u>					ADDRESS <u>Sparks Ind</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Baltimore

14719

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City Catonsville (No. Rolling Road St.        Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Frank Primrose

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH October 26, 1868  
(Month) (Day) (Year)

7 AGE 62 yrs. 2 mos. 3 ds. or        min.?  
If LESS than 1 day        hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer)       

9 BIRTHPLACE (State or country) Baltimore, Maryland

10 NAME OF FATHER William F. Primrose

11 BIRTHPLACE OF FATHER (State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER Josephine Hand

13 BIRTHPLACE OF MOTHER (State or Country) Phila., Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. H. Clay Primrose

(Address) 505 Cathedral St.

15 Filed 12/31 1930 Joseph H. Hook Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 30th, 1917 to Dec 29th, 1930  
that I last saw him alive on Dec 29th, 1930

and that death occurred on the date stated above, at 9.50 P. m.  
The CAUSE OF DEATH \* was as follows:  
Left Cerebral hemiplegia

Contributory (Duration) 13 yrs. 1 mos. 29 ds.  
Secondary Fifth stroke, Left Cerebral hemiplegia  
(Duration)        yrs.        mos. 1 ds.

(Signed) Frederick Ave. M. D.  
Dec 29 th 1923 (Address) Catonsville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL London Park Cemetery DATE OF BURIAL Dec. 31, 1930

20 UNDERTAKER Joseph H. Hook ADDRESS 1003 West Baltimore St.

If more blanks are needed, add to the Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *legibus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1931

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Anne Arundel Co.</u> <u>Baltimore County</u>		08997 (47)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rosemont</u> (No. <u>Alabama Ave.</u> )		Ward <u>42</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Clara E. Pruitt</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Sept. 30, 1886</u> (Month) (Day) (Year)					
7 AGE <u>43</u> yrs. <u>10</u> mos. <u>27</u> ds. If LESS than 1 day hrs. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>at home</u>					
9 BIRTHPLACE (State or country) <u>Md.</u>					
10 NAME OF FATHER <u>Saib Brown</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>					
12 MAIDEN NAME OF MOTHER <u>Lucritia Welsh</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. L. Pruitt</u> (Address) <u>Alabama Ave. Rosemont</u>					
15 Filed <u>Aug 29 1920</u> <u>He Kieffer</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug. 26, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>April 1, 1930</u> to <u>Aug. 26, 1930</u> that I last saw him alive on <u>Aug 25, 1930</u> , and that death occurred on the date stated above, at <u>9.45 P.m.</u> The CAUSE OF DEATH * was as follows: <u>Carcinoma of left breast with general metastasis</u> (Duration) <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. Contributory Secondary <u>Cachexia</u> (Duration) <u>3 or 4 weeks</u> (Signed) <u>Harry A. Witke</u> M. D. <u>Aug. 27, 1930</u> (Address) <u>1224-1226 Hanover St</u> *State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. In the State <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Sykesville, Md.</u>				DATE OF BURIAL <u>8/30/30</u> , 19	
20 UNDERTAKER <u>Harry A. Witke</u>				ADDRESS <u>4101 Edmondson Ave</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 8 1900  
BUREAU OF





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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OCT 6 1930

BUREAU

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## 1 PLACE OF DEATH

County

*Baltimore*

04026

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *41*

Village or City

*Golgato*

(No. \_\_\_\_\_)

St.

*Trappe Road*

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Baby Protowski*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Single*

6 DATE OF BIRTH

*April 18, 1930*  
(Month) (Day) (Year)

7 AGE

\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

If LESS than 1 day, \_\_\_\_ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

*Maryland*

10 NAME OF FATHER

*Mick Protowski*

11 BIRTHPLACE OF FATHER

(State or country)

*Russia Poland*

12 MAIDEN NAME OF MOTHER

*Pauline Wiligko*

13 BIRTHPLACE OF MOTHER

(State or country)

*Russia Poland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mick Protowski*

(Address)

*Trappe Road Gulgato*

15 Filed

*4/18/30**Wm. Kearns*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*April 18, 1930*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*April 18, 1930 to April 18, 1930*that I last saw him *alive still born*, 192\_\_\_\_and that death occurred on the date stated above, at *4:54* m.

The CAUSE OF DEATH \* was as follows:

*Stillborn*Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

*Wm. R. R. R.*

M. D.

*April 18, 1930* (Address) *Conrad Rd*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Christ Lutheran Ch.**April 18, 1930*

20 UNDERTAKER

ADDRESS

*H. Sander Sons**1710 Fleet St*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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RECEIVED  
MAY 5 1930  
BUREAU

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
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1 PLACE OF DEATH  
County Baltimore

Village or City Catonsville (No. 6 from an St. an Ward)

06504 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 30

2 FULL NAME Elmer Pullman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 6, 1926  
(Month) (Day) (Year)

7 AGE 42 yrs. 2 mos. 22 ds. or less than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House & child  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto Md

10 NAME OF FATHER Clarence Pullman

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Young

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Pullman

(Address) 6 Jones Baltimore

15 Filed 4-28-30 Attest Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 27, 1930 to June 28, 1930, that I last saw him alive on June 28, 1930,

and that death occurred on the date stated above, at 3 9 a.m.

The CAUSE OF DEATH \* was as follows: Acute endocarditis

(Duration) Unknown yrs. mos. ds.

Contributory Secondary Unknown

(Duration) Unknown yrs. mos. ds.

(Signed) W. H. H. H. H. M. D.  
June 28, 1930 (Address) Catonsville, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death Unknown yrs. mos. ds. In the State Unknown yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western Market

DATE OF BURIAL 6-30-30

20 UNDERTAKER George T. Gibson

ADDRESS 1735 Spring



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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1 PLACE OF DEATH

County Baltimore

(162)

13590

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Carney(No. Harford RdSt. HarfordWard) Harford

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Infant of Howard & Gertrude Pinter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Nov. 3, 1930  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day hrs.  
yrs. mos. ds. or 30 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Maryland

10 NAME OF FATHER

Howard Pinter

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Gertrude Birkentech

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Pinter(Address) Carney Ind.15 Filed 11/4 1930 C. M. Bacon

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 3, 1930  
(Month) (Day) (Year)

17

1 HEREBY CERTIFY, That I attended the deceased from

11/3 1929 to 11/3/30 1929that I last saw him alive on 11/3/30 1929and that death occurred on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH \* was as follows:

apoplexy

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Walter H. H. H. M. D.11/4 1929 (Address) 503 W. 1st St.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Parkwood Cem.

DATE OF BURIAL

11/4 1930

20 UNDERTAKER

Fred. Lassahut Son

ADDRESS

Fullerton

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as "Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

DEC 6 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

Village or City Lansdowne No. Howard Ave. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 42

2 FULL NAME Wilford Greenburg Purdum

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 21, 1889  
(Month) (Day) (Year)

7 AGE 41 yrs. 2 mos. 0 ds. or LESS than 1 day     hrs.     min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Fireman  
(b) General nature of industry business, or establishment in which employed or (employer) B & O R R.

9 BIRTHPLACE (State or country) Frederick Co. Md

10 NAME OF FATHER Jos. A. Purdum

11 BIRTHPLACE OF FATHER (State or country) Fredk Co. Md

12 MAIDEN NAME OF MOTHER Illa Sartrell

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Susie M. Purdum

(Address) Howard Ave. Lansdowne

15 Filed Sept 23 19230 Herbie

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from Mar - 1928 to Sept 22, 1930

that I last saw him alive on Sept 20, 1930

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH \* was as follows:

Splenic Myelogenous Leukemia  
(Duration) 2 yrs. 6 mos.     ds.

Contributory  
Secondary

(Signed) Chas A. Eakin M. D.  
9/22 19230 (Address) 2145 N. Balt. H

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death     yrs.     mos.     ds. In the State     yrs.     mos.     ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prospect Cem. Mt Airy, Md Sept. 24, 1930

20 UNDERTAKER

ADDRESS

Wm. J. Tickner & Son North & Pa Ave.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Mr. Chas. N. Kahn  
3145 N. Balto. St.

OCT 2 1930



MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Balto.

2 FULL NAME Baby Euvance

Village or City Towson (No. Prospect Hill St.        Ward       )  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 7, 1930  
(Month) (Day) (Year)

7 AGE Stillborn  
yrs. mos. ds. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Albert Euvance

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Sarah Johnson  
(Address) Prospect Hill Md

15 Filed May 7 19230 Wm C. Butler, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 7, 1930 to May 7, 1930  
that I last saw h        alive on       , 19230  
and that death occurred on the date stated above, at 12:15 m.  
The CAUSE OF DEATH \* was as follows:  
Stillborn  
(Duration) yrs. mos. ds.

Contributory Secondary  
(Duration) yrs. mos. ds.

(Signed) L. A. Johnson M. D.  
May 8, 1931 (Address) 2329. Guilford L.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Chesant Rest - Town DATE OF BURIAL 5/8/30

20 UNDERTAKER Mrs Geo. H. Holland ADDRESS 1631 Dismick St

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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